WESTWOOD PUBLIC SCHOOLS
HEALTH INFORMATION

Student Name: _____ **Date of Birth:** _____/_____/_____ **Sex:** ❑ M ❑ F **Grade:** _____

Health Care Provider: _____ **Dentist:** _____

Type of Medical Insurance: ❑ Private ❑ MassHealth ❑ Military ❑ Children's Medical Security Plan ❑ None

❑ Other: _____

Medical History (check the ones that apply to your child):

❑ ADD/ADHD
❑ Alcohol/Drug Misuse
❑ Anorexia/Bulimia
❑ Anxiety/Panic Attacks
❑ Asthma
❑ Bleeding Disorder
❑ Color Blindness
❑ Diabetes
❑ Dental Problem
❑ Eczema
❑ Fainting Spells
❑ Frequent Earaches/Infections
❑ Headaches
❑ Hearing Problem
❑ Heart Condition
❑ Kidney/Bladder Problem
❑ Menstrual Problem
❑ Muscle Disorder
❑ Neurological Disorder
❑ Orthopedic Condition
❑ Seizures
❑ Speech Problem
❑ Toileting Difficulties
❑ Vision Problem

*If you have checked **any of the above**, please explain and give dates:* _____

_____

Allergies: ❑ Plants ❑ Foods ❑ Bees or Insects ❑ Animals ❑ Medication: _____
❑ Other: _____

Is medication needed for any condition: at home? ❑ Yes ❑ No **at school?** ❑ Yes ❑ No

Name of medication: _____ Dosage: _____

Reason needed: _____

List any operations, injuries, hospitalization or prolonged illness and give dates: _____

_____

_____

List any past or current mental health concerns: _____

_____

_____

Recommended Physical Activity (please check one):

❑ Full Activity/Sports ❑ Modified/Restricted Activities ❑ If restrictions, please explain: _____

_____

Does your son/daughter wear glasses? ❑ Yes ❑ No **Does your son/daughter wear contact lenses?** ❑ Yes ❑ No

Is your child receiving any outside services (counseling, speech, physical therapy, tutoring, etc.)? _____

_____

Is there anything you can tell us about your son/daughter that you feel will help the school staff to better understand and work with him/her? _____

_____

Please contact the School Nurse if your child has a serious medical condition or if you have any questions or concerns.

SIGNATURE: _____ **DATE:** _____