WALNUT CREEK SCHOOL DISTRICT

HEALTH INFORMATION FORM

Parent to fill in and return to school.

Name _____ Birthdate _____ School _____

Physician's Name _____ Date of last exam _____

1. IMMUNIZATIONS. You will be asked to provide the school with a medical record for all immunizations. Students who are not adequately immunized will not be allowed to attend school.
* New Tdap (pertussis) booster is REQUIRED as of July 1, 2011

2. DISEASE HISTORY. Please check any that apply to your child.

_____Acne
_____Asthma
_____Diabetes
_____Fainting spells
_____Headaches
_____Hearing problem
_____Heart Condition
_____Hernia
_____Menstrual pain
_____Nosebleeds
_____Operations
_____Seizures
_____Other health conditions

3. ORTHOPEDIC PROBLEMS. Please check any that apply to your child.

_____Poor posture
_____Flat feet
_____Bone disease
_____Poor muscle coordination
_____Joint pains
Where?_____
_____Easily dislocated joints
_____Other

Please explain any of the above _____

4. Does your child wear any of the following:

_____Glasses
_____Contact lenses
_____Dental braces
_____Hearing aid
_____Leg braces
_____Corrective shoes
_____Other

Name of the eye doctor _____ Date of last eye exam _____

5. Is your child taking any medication prescribed by a physician? Yes_____ No_____
If yes, please explain _____
(Medication may be given at school only upon written request from the parent or physician.)

6. Does your child have any condition which could become an emergency at school? Yes___ No____
If yes, please explain _____
_____
You may be asked to obtain or provide further information on your child's condition.

7. I certify that my son/daughter _____ is able/not able (circle one) to participate in the physical education program, including the physical fitness testing. (If there are any restrictions which would limit participation in the PE program, a physician's report is desirable.)

Date _____ Parent Signature _____

PHYSICIAN'S REPORT

Student's Name_____ _____ _____
Last First Birthdate Grade

Parent's Name_____ Phone_____

Adress_____

Parent's Authorization:
I hereby give my consent to the Walnut Creek School District to receive from or send to my student's Medical Advisors any information which concerns my student's health.

*Signature of Parent/Guardian*_____

HISTORY OF IMMUNIZATIONS AND SPECIAL TESTS

Polio	#1_____, #2_____, #3_____, #4_____
DTP	#1_____, #2_____, #3_____, #4_____, #5_____
MMR	#1_____, #2_____
Hepatitis B	#1_____, #2_____, #3_____
Varicella	#1_____, #2_____ _____ had disease_____Dr's signature/date
Tdap	_____date *new Tdap (Pertussis) booster is required as of July 1, 2011
TB skin test	#1_____, #2_____ Positive_____ Negative_____

MEDICAL HISTORY-EXAMINATION-RECOMMENDATIONS

Have any previous tests or immunizations caused severe illness?

Does the child have: Asthma_____
Eczema_____ Allergies_____
Comments:

Is there any known vision or hearing problem for which the school could compensate by proper seating or other action?

Recommendations:

Is there any health problem which limits participation in:
a) Classroom Activities
b) Physical Education
c) Competitive Athletics (indicate which)

Recommendations:

Is this student subject to any condition for which the school should make special preparation: eg epilepsy, fainting, diabetes, heart disease, other?

Recommendations:

Is there any emotional, mental or physical condition for which this student should remain under periodic medical observation?

Recommendations:

Other comments/observations:

_____ _____ _____
Name of Examining Physician Address Date