South Whitley Community Preschool

Building foundations • Building minds • Building community

STUDENT HEALTH HISTORY

NAME _____ DATE OF BIRTH _____

PARENT OR GUARDIAN _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ DOCTOR _____

HEALTH INFORMATION

Please check any area that applies to your student and explain on the line following.

- ☐ Glasses/contacts _____ Date of last exam _____
- ☐ Asthma/respiratory diagnosis _____
- ☐ Uses an inhaler _____
- ☐ Convulsions/seizures _____
- ☐ **Severe allergy** to insects, plants, or food requiring Epinephrine Pen: _____
- ☐ **Allergy to insects, plants or food requiring Benadryl** _____
- ☐ Specific dietary restrictions due to medical problems _____
- ☐ Heart problems _____
- ☐ Please list any other medical conditions your child may have _____

_____

Medications taken at home _____

*I give my permission for this information to be shared with the preschool staff and emergency medical staff that might have direct contact with my child.

*I give permission for school staff to care for and to meet the immediate health needs of my child.

*I understand that my child will be treated by the preschool staff.

*Every effort will be made to contact you in the event of a medical emergency. In the event I cannot be reached, I give my permission for my child _____ to be transported by EMS if deemed necessary by emergency medical staff.

Parent/Guardian Signature _____ Date _____