WOODRUFF HIGH SCHOOL HEALTH FORM

GRADE: _____

Student's Name:	Sex:	Race:	DOB:
Parent/Guardian Name:			
Home #:	Work #:	Cell #:	
Emergency Name:	Home #:		
	Cell #:		

Please check below any problems that pertain to your child. Provide necessary explanation in the comment area. ***Please see the school nurse.**

____ Asthma*
____ Allergies*
____ Insect Stings __ Epi pen*
____ Hay fever
____ Skin Problems
____ Nervous Stomach
____ Headaches
____ Speech Problems
____ Kidney Problems
____ Eating Disorder
____ Special Diet
____ High Blood Pressure
____ Low Blood Sugar
____ Blood Problems (anemia, sickle cell, hemophilia)
____ Diabetes __ ck at school? __ injections? __ pump?
____ Orthopedic problems
____ Skeletal/Muscular Problems
____ Eye Problems __ glasses? __ contacts?
____ Ears __ tubes? __ hearing aid?
____ Seizures _____type _____ date last seizure*

Comments:
_____
_____
_____

Prescription and over the counter medication procedures and policies are located in the WHS Handbook on page 37.

This form is maintained in your child's confidential health record so that in an emergency, school officials may have necessary critical information to provide emergency care. In the event parents cannot be located, school officials will take appropriate action deemed necessary in their judgement for the health of your child.

Parent Signature: _____ Date: _____