WEST FARGO PUBLIC SCHOOLS STUDENT HEALTH HISTORY

Name: _____ Birthdate: _____ Grade: _____ F ___ M ___

☐ My child has NO medical conditions or concerns

☐ Yes, my child has the following medical conditions or concerns:

Life Threatening Conditions

____ **Asthma** Does your child use a rescue inhaler more than once a week? _____
Has your child been hospitalized for asthma symptoms in the past year? _____
Has your child used steroids for asthma symptoms in the past year? _____

____ **Allergy** **Please check only if Severe and Epinephrine is prescribed. Ex: peanuts, bees, tree nuts, etc.**
Allergen(s) _____

____ **Diabetes** Diagnosis date: _____ Type 1 **or** Type 2 CGM: Yes No
Pump **or** Injections Manages Independently **or** Needs Assistance

____ **Seizures** Type: _____ How Often: _____
Do your child's seizures require medication at home? _____
Does your child require emergency seizure medication at school? _____

____ **Other** _____

Does your child need an Emergency Care Plan for school? _____ Yes _____ No
If yes, please complete the appropriate Emergency Care Plan and medication forms. ***Physician signature is required.*
Forms are available on the WFSD website - *www.west-fargo.k12.nd.us,* or in your school nurse office.

Other Medical Conditions: Please check all that apply

_____ ADD/ADHD _____ Blood Disorder _____ Concussion _____ Dental

_____ Dietary Concern _____ Hearing _____ Vision _____ Heart Condition

_____ Migraines/Headache _____ Mental Health Please explain: _____

If you have checked any of the above, or your student has a medical condition not listed, please explain:
_____

Allergies (non-life threatening):

____Nuts ____Foods ____Bee/Insect ____Seasonal ____Drugs ____Other: _____

If yes, what is the allergic reaction and treatment: _____
_____

Special Notes:

***If your child needs to take any medication at school, including emergency medications (like an inhaler, EpiPen, Diastat, or Glucagon), you must complete a WFPS Medication Administration Form.**

PARENTS OF STUDENTS OF GRADES 1- 12

*If you would like your student to have permission for school supplied Acetaminophen as needed, please initial below.

GRADES 1-5:
Acetaminophen 325 mg - 1 tab _____

GRADES 6-12: (Please choose which dose your student may have)
Acetaminophen 325 mg - 1 tab _____
Acetaminophen 650 mg - 2 tabs _____

***In case of an emergency, permission is granted to take my child to a licensed medical facility as deemed necessary by staff.**

First Hospital Preference: Essentia _____ Sanford _____ Either _____

Parent/Guardian Signature: _____ Date: _____