Johnson Creek School District
455 Aztalan Street
PO Box 39
Johnson Creek, WI 53038
Phone: 920.541.4800
Fax: 920.541.4850

Johnson Creek Health History

PLEASE PRINT

Child's Name: (Last)_____ (First)_____ (MI)_____

Birthdate: _____Grade:_____ Address:_____

Parent/Guardian Name:_____ Contact Number:_____

Emergency Contact/Relationship:_____ Contact Numbers:_____

Primary Care Physician: _____ Name of Medical Facility:_____

Address of Physician/Medical Facility:_____

Phone Number:_____ FAX Number:_____

Dentist: _____ City:_____

Dentist's Phone Number:_____ Date of last dental exam:_____

PHYSICAL ASSESSMENT

	WNL	ABN		WNL	ABN
General Appearance			Teeth		
Skin			Lungs		
Eyes			Heart		
Ears			Abdominal Exam		
Nose, mouth, throat			GU/GYN Exam		
Lymph Nodes			Musculoskeletal		
Thyroid			Gait/Posture		

LABORATORY

Height: _____ Weight:_____ Blood Pressure:_____

Vision: Both: 20/_____ Right: 20/_____ Left: 20/____

Hearing: Right Ear: _____@1000 _____@2000 _____ @4000

Left Ear: _____ @1000 _____@2000 _____@4000

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Allergies:_____ EPI Pen needed: NO YES

(Allergies with prescribed EPI will need a signed SEVERE ALLERGY ACTION PLAN found on the district website)

Medical condition(s) of significance as observed by the health examiner:_____

_____

_____Asthma _____ ADD/HD _____Diabetes _____Seizures/Epilepsy (last seizure_____) _____Migraines

Describe any physical, behavioral, developmental, or emotional concerns:_____

_____

Describe any limitations/restrictions in activity:_____

_____

Are immunizations up to date? NO YES

Immunizations given:_____

Is your child taking medication? NO YES - Name of Medication/Dose:_____

Reason for taking the medication:_____

Will this child need to have this medication administered during the school day :_____ NO _____ YES - if so, **PLEASE COMPLETE A MEDICATION ADMINISTRATION FORM FOUND ON THE DISTRICT WEBSITE AND RETURN TO THE HEALTH SERVICES OFFICE WITH APPROPRIATE SIGNATURES. MEDICATIONS WILL NOT BE ADMINISTERED AT SCHOOL WITHOUT THE PROPER SIGNED FORMS ON FILE.**

Name of Health Care Examiner:_____

Signature of Health Care Examiner:_____Date:_____

If your child has a significant health history, the health services office may request that a signed **INFORMED CONSENT FOR RELEASE OF INFORMATION** form be kept on file to promote communication between the school nurse and your child's health care practitioners as needed. This form can be found in the school and health services offices.

School personnel with whom your child interacts, will have access to your child's pertinent health information, on a need-to-know basis only, for safety reasons.

I give permission to have my child participate in the screening programs for vision and hearing.

Parent/Guardian Signature:_____ Date:_____