WILLAMETTE KIDS
Child Development Center
www.WILLAMETTE.KIDS | 2500 W 18TH AVENUE, EUGENE, OR 97402 | 541.686.8651

STUDENT HEALTH FORM

Today's Date: _____

This information will enable us to be aware of any health-related concerns or emergencies that may arise. This is kept confidential in your child's cumulative health folder for professional use only.

Student's Full Name: _____Grade: _____Date of Birth: _____

Medical Treatment Release

In the event of an emergency and I am unavailable, I authorize school personnel to make arrangements for my child to receive medical care, including required transportation in an ambulance to the nearest hospital or treatment facility. I authorize the physician and/or dentist named below to undertake such care as is considered necessary. In the event said physician is unavailable, I authorize such care and treatment to be performed by a licensed physician and surgeon. I agree to bear all costs incurred.

Parent/Guardian Signature: _____Date: _____

Parent/Guardian Printed Name: _____

May Tylenol or Advil (or equivalent brand) be given to the student if needed? ☐Yes ☐No Please Initial: _____

Medical Service Information

Physician: _____Address: _____Phone: _____

Dentist: _____ Address: _____Phone: _____

Insurance Information:

Does your student have medical insurance coverage? ☐Yes ☐No

Insurance Company: _____Membership No. _____Group No. _____

Primary Insured: _____Primary Insured's Membership No. _____

Does your student have dental insurance coverage? ☐Yes ☐No

Insurance Company: _____Membership No. _____Group No. _____

Primary Insured: _____Primary Insured's Membership No. _____

**In the event of emergency transport, your student will be taken to River Bend Hospital in Springfield, OR unless otherwise directed by emergency personnel.

General Information

Current medications taken (list both prescription & nonprescription medications including vitamins/herbs):

Drug name _____Dose_____Administered at school? ☐Yes ☐No

Drug name _____Dose_____Administered at school? ☐Yes ☐No

Drug name _____Dose_____Administered at school? ☐Yes ☐No

Drug name _____Dose_____Administered at school? ☐Yes ☐No

STUDENT HEALTH FORM (Page 2)

Does your student:

Wear glasses?	☐Yes ☐No	**Contacts?**	☐Yes ☐No		
Have hearing loss?	☐Yes ☐No	**Use hearing aids?**	☐Yes ☐No		
Have a history of:	☐Asthma	☐Bee Sting Allergy	☐Diabetes	☐Epilepsy	☐Heart Condition

Please enter date or age of occurrence or diagnosis for the following:
Chicken Pox_____ Neurological Problems _____TB Contact _____
Orthopedic Problems _____Serious Injury _____Frequent headaches_____

Does your student have any allergies? If none, write "none". Please be specific, attach additional sheets as needed.

_____

Are there any medical conditions that would limit your child's normal school activities? ☐Yes ☐No
If yes, explain:

_____
_____
_____

Emotional/Psychological Information

Has your student experienced a recent significant loss of a loved one or other emotional distress? ☐Yes ☐No
(Loss of grandparent, pet, divorce, etc.)
If so, please explain:

_____
_____
_____

Is your student currently under the care of a child psychologist/counselor? ☐Yes ☐No If so, please explain.

_____
_____
_____

Does your student have problems with temper tantrums or emotional outburst? ☐Yes ☐No

Does your student show signs of hyperactivity or attention difficulties? ☐Yes ☐No

Has your student been diagnosed with an attention deficit disorder? ☐Yes ☐No ☐ADD ☐ADHD

Has your student been diagnosed with a sensory integration disorder? ☐Yes ☐No ☐SPD ☐Autism ☐PDD

Other

Please note any additional comments or concerns you would like us to know about your student's health. If you need more space, feel free to add another page.

_____
_____
_____
_____