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.

Child's Full Name: _____Age: _____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 sunblock, antibiotic ointment, first aid wipes, and sting relief pads be applied to child at the discretion of trained staff?
☐Yes ☐No Please Initial: _____ If no, please meet with center director to discuss reasons and alternatives.

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

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STUDENT HEALTH FORM (Page 2)

Does your student:
Wear glasses? ☐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.

_____

Does your student have any **food intolerances** that cause significant change in child's mood, comfort, or digestion?

_____

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 significant loss of a loved one or other emotional distress? ☐Yes ☐No (Loss of family member, pet, divorce, displacement, 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 outbursts? ☐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

If yes to any of the above, please explain what methods you have used to help your child cope on a daily basis, and the results (use additional sheet if needed):

_____
_____
_____

STUDENT HEALTH FORM (Page 3)

TOILET TRAINING

My child is currently:

☐ Showing no interest in potty training. ☐ Showing signs of potty-training readiness ☐ Actively potty-training at home ☐ Is potty-trained while awake only (wears a diaper/pullup at naptime) ☐ Is fully potty-trained (no accidents for at least a 14-day period)

NOTE: For potty-training children please bring 3 extra pairs of underwear & bottoms + 1 extra pair of shoes.

REST TIME HABITS

For preschool age and younger children, a certified child care center must include one or more regularly scheduled rest periods. Please provide a small blanket, pillow, and (if needed) one soft & quiet comfort item from home. All rest items should fit in child's cubby and go home to be laundered at the end of the week.

Does your child still take regular naps? ☐Yes ☐No

If yes, describe the time of day, typical duration, and pre-rest/wake-up routines:

_____
_____
_____

Does your child sleep well at night? If not, please explain:

_____
_____
_____

MORE ABOUT MY CHILD:

Please tell us more about your child! What are some of *your* favorite things about *them*? What are some of *their* favorite things to say, do, play with, or explore? What are some of your child's favorite things to say/sing?

_____
_____
_____
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_____

OPTIONAL HOME VISIT

Making the child's experience in our center as familiar and comfortable as possible is one of our goals. Please consider setting up a time with your child's teacher or the center director for a home visit. Outside of center hours, what day/time would be best for a home visit? Day of the week:_____ Time of day_____