Westford Massachusetts

WESTFORD PUBLIC SCHOOLS
INFORMATION FOR STUDENT HEALTH RECORD

Please Print

Student Name (Last, First, Middle)	Birth Date (MM,DD,YYYY)	Gender: Circle One
Address (Street, Town, State, ZIP code)		
Guardian's Name (Last, First)	Relationship to student	Phone Number
Guardian's Name (Last, First)	Relationship to student	Phone Number
Entering Grade	Previous School	
Pediatrician	Location	Phone Number
Dentist	Location	Phone Number

Allergies: ☐ My child **HAS** the following allergies ☐ My child has **NO** allergies Is an Epi-pen prescribed? *Yes___ No___

Medication child is allergic to:_____ Environmental:_____
Foods:_____ Bee/insect_____ Latex_____ Other_____

Respiratory:☐ My child **HAS** asthma ☐History of reactive airway and/or wheezing ☐ My child has **NO** respiratory history If Yes:
Is an Inhaler currently Prescribed? *Yes___ No____ Will you be providing an inhaler to the clinic? Yes_____ No_____

Diabetes: ☐ My child **HAS** diabetes ☐ My child has **NO** history of diabetes
If Yes:
Is insulin Prescribed? *Yes___ No____ Treatment Plan:_____

Seizures: ☐ My child **HAS** a history of seizures ☐ My child has **NO** history of seizures If Yes
Explain:_____ Is medication prescribed? *Yes___ No____ Will you be providing seizure medication to the clinic? Yes_____ No_____

PLEASE COMPLETE BOTH SIDES → Page 1 of 2

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Please check all conditions that apply, and explain as needed on the conditions with line space:

Eye/ Ear	Cardiac/ Respiratory	GI/GU	Neurological	Other	Other Con't
☐ Eye Condition _____	☐ Congenital Heart condition	☐ Celiac	☐ Headaches	☐ ADD/ADHD	☐ Eczema/skin issues
☐ Eyeglasses/contacts	☐ Cystic Fibrosis	☐ Constipation ☐ Incontinence	☐ History of concussion Date_____	☐ Anxiety	☐ Nosebleeds
☐ Ear condition _____	☐ Heart Murmur	☐ Lactose Intolerance	☐ Migraines	☐ Arthritis	☐ Scoliosis
☐ Hearing aid	☐ History fainting	☐ Frequent Stomach aches	Neuromuscular Condition	☐ Autism Spectrum Disorder	☐ Strep throat (Frequent history)
☐ Multiple Ear infections Tubes? Yes☐ No☐	☐ Lung Condition _____	☐ Gastric reflux		☐ Cerebral Palsy	☐ Trouble sleeping
		☐ Kidney/bladder		☐ Developmental Delay	☐ Allergies (Food, Seasonal, medicine?) _____ _____

History of Hospitalization/Surgery? ☐Yes ☐No
Reason:
_____

Emotional/Behavioral Concerns? ☐Yes ☐No
If yes explain:_____

Other Pertinent Medical History:
_____
_____

History Learning Disability? ☐Yes ☐No If yes, please select one ☐ Current IEP? ☐ Current 504?

Medications: Please list medications your child is taking Required to be given in school?

Medication #1: _____ Time: _____ Dose: _____ ☐Yes ☐No

Medication# 2: _____ Time: _____ Dose: _____ ☐Yes ☐No

Medication# 3: _____ Time: _____ Dose: _____ ☐Yes ☐No

I give permission to the nurse to speak with the above listed doctor/s to meet my child's health and safety needs.

YES ☐ NO ☐ _____ _____
Caregiver/Guardian's Signature Required Date

If needed, I give permission to the nurse to share the following provided information with the appropriate school personnel to meet my child's health and safety needs.

YES ☐ NO ☐ _____ _____
Caregiver/Guardian's Signature Required Date

SHAPING THE FUTURE ONE CHILD AT A TIME
Revised July 2022