

Medical Information and Health History

Does your child have any of the following conditions? *Please circle all that apply.*

- | | | | |
|-------------------|---------------------|---------------------|-----------------|
| Allergies | Chicken Pox | Intestinal Problems | Tuberculosis |
| Anorexia/Bulimia | Cystic Fibrosis | Leukemia | Vision Problems |
| Arthritis | Depression | Multiple Sclerosis | Ulcers/GERD |
| Asthma | Diabetes | Prosthesis | Weight Problems |
| Autism | Ear Infections | Scoliosis | Other: |
| Bee stings | Hearing Problems | Hyperactive/ADHD | Severe Acne |
| Bladder Infection | High Blood Pressure | Seizure/Epilepsy | Spina Bifida |
| Cerebral Palsy | Cancer | Sinus Problems | Thyroid Disease |

If you circle any of the above, please explain: _____

Is your child on any medication at this time? ____ Yes ____ No

If yes, will your child require any medication during school hours? ____ Yes ____ No

List daily medications: _____

Does your child have any activity restrictions? _____

Will your child need special health care procedures at school? ____ Yes ____ No

If yes, what type of procedure? _____

Other Health Information/Special Education: _____

Name of Insurance Company: _____ Policy # _____

Family Physician	Address	Phone #
Dentist	Address	Phone #
Hospital	Address	Phone #

Please Note: In the event of a serious accident/illness, emergency medical services will be called. The student may be transported to the nearest hospital at the parent/guardian's expense.

This information, along with my child's immunization record, may be shared with school personnel, wellness center personnel and other health professionals pertinent to my child's health. My child's immunization record can be shared with the West Virginia Statewide Immunization Information System.

Signature of Parent/Guardian: _____ **Date:** _____

Verifying Staff Member: _____ **Date:** _____

Family Information

CACEP Status: Free/Reduced CACEP Date: _____ CACEP Income: _____
 Foster Care: _____ Child Support: _____ WIC: Yes or No
 SNAPS: Yes or No TANF: Yes or No SSI: Yes or No

Name of Member	Date	Source	Amount	Per	Annual Amt.	Type	Desc. Code	Verification Code	
Type Code ERN SUB = Subsidized		Description Codes PEN = Pension SSI = Supplemental Social Security SS = Social Security				Verification Codes CS = Check Stub W2 EL = Employee Letter TANF			

Household Members

First & Last Name	Status	Birth Date	Gender	Relationship to Child	Language	Lives w/ Family	Provides Financial support	Highest Grade Comp.	Employment Status
			M F						
			M F						
			M F						
			M F						
			M F						
			M F						

Signature of Parent/Guardian: _____ Date: _____

Verifying Staff Member: _____ Date: _____