SUPPLEMENTAL SCHOOL HEALTH REPORT

Student's Name: _____ Age: _____ Grade: _____

Date of last dental exam: _____ New glasses/lenses? YES NO

Date of last vision exam: _____

Please Circle YES or NO

YES NO Did your child have an illness or accident during the summer?
If yes, please explain: _____

YES NO Did your child have any immunizations during the summer?
If yes, please list date and what was given: _____

YES NO Is your child allergic to medication, food, bee stings or environmental allergens?
If yes, list ALL allergens and reaction for each: _____

YES NO Does your child take medication(s) on a regular basis?
If yes, list name(s) and times taken: _____

_____

YES NO Does your child have a medical diagnosis of a chronic health condition such as diabetes, asthma, heart problems, seizures, etc.?
If yes, list medical condition: _____

Additional information: _____

_____ _____
Parent/Guardian Signature Date

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MEDICATION REQUEST

It is the policy of the Waukee Community School District that whenever a student should have a prescription medication or over-the-counter medication administered by school staff, a parent or legal guardian must provide written authorization and instruction. All over-the-counter medication MUST be in the original container. Prescription medication MUST be in a properly labeled container issued by a registered pharmacist with the following information: Name of medication, Dosage, Time medication is to be given at school, Name of student, AND Prescribing physician.

_____ is to be given the following medication at school:
(name of student)

Name of Medication	Dosage	Time	Prescribed by
_____	_____	____	_____
_____	_____	____	_____

How long is this medication to be given? Date from _____ to _____

Are there any special instructions? _____

_____ _____
Parent/Guardian Signature Date