Wellington School Health Record

_____

Child's Name (Last, First, Middle) Date of Birth Grade

Is there anything about your child that we need to know to better understand him / her?

List any diseases, serious injuries, allergies or asthma that your child has had and give dates (year only).

List any medications or treatments your child receives at home. Are any required at school?

The Wellington School
Physical Exam Report
(A physical exam is required for new, Little Jag, and PK students only)

Student's Name_____ Grade_____
Healthcare provider, check one:
_____ Exam entirely within normal limits
_____ Abnormalities as follows:
Can student carry out a full program of school work?
Yes _____ No _____
Restrictions:

Healthcare Provider's Signature _____Date _____

IMMUNIZATIONS Not all date boxes will be filled. A separate list may be attached.

	Mo Day Yr	Mo Day Yr	Mo Day Yr	Mo Day Yr	Mo Day Yr	Mo Day Yr
DTaP/DT/Td	/ /	/ /	/ /	/ /	/ /	/ /
Polio	/ /	/ /	/ /	/ /	/ /	/ /
Hepatitis B	/ /	/ /	/ /	/ /	/ /	/ /
MMR	/ /	/ /	/ /	/ /	/ /	/ /
Varicella	/ /	/ /	/ /	/ /	/ /	/ /
Tdap (7th grade)	/ /	/ /	/ /	/ /	/ /	/ /
Meningococcal 7th & 12th	/ /	/ /	/ /	/ /	/ /	/ /
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Screening Tests	Date	Results
Muscle Balance		
Farsightedness		
Color		
Distance Acuity		Right Left
Hearing		Right Left

THE WELLINGTON SCHOOL EMERGENCY INFORMATION

Part I

Student_____ Grade_____Date of Birth ____/____/_____

Parents _____ Home Phone _____

Address _____ City_____ Zip_____

Parent #1 Business Phone _____ Parent #1 Cell _____

Parent #2 Business Phone _____ Parent #2 Cell _____

Part II **EMERGENCY CONTACTS IF PARENTS CANNOT BE REACHED** (please complete all lines)

Who should we call to care for your child if you are not available (relative, friend)?

1. _____

Address_____ Phone_____

2. _____

Address_____ Phone_____

Part III **MEDICAL HISTORY**

List health conditions_____

Medications _____

Asthma? (Circle One) Yes No Will your child carry an inhaler at school? (Circle One) Yes No

Medications for asthma _____

Allergies? (Circle One) Yes No

To what is child allergic? _____

Symptoms caused by allergy _____

Treatment for allergy_____

Physical impairments_____

Additional information_____

Part IV **CONSENT FOR TREATMENT AND TRANSFER** (please complete all lines)

In the event of a serious emergency, 911 will be called immediately and the school will continue attempts to reach a parent. If reasonable attempts to contact me at the above telephone numbers have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the preferred doctor indicated, or, in the event the preferred practitioner is not available, I give consent to treatment by another licensed physician or dentist; and (2) the transfer of my child to any hospital reasonably accessible; and (3) surgery, only if two licensed physicians agree that it is necessary to proceed without me. The school cannot assume responsibility for care of ill or injured students beyond the administration of first aid.

→_____ _____

Parent Signature Date

I hereby give consent for the following medical care providers and local hospital to be called:

Physician _____

Address _____ Phone _____

Dentist _____

Address _____ Phone _____

Hospital _____

Part V **CONSENT FOR PAIN RELIEVER IF NEEDED** (K-12)

I give the school nurse permission to administer a pain reliever (Tylenol or ibuprofen) to my child, if needed, in the appropriate dose.

→_____ _____

Parent Signature Date

The Wellington School
Dentist's Report

Student's Name _____ Grade _____

The following services have been performed:
(Please check all that apply)

_____ Radiographs

_____ Oral prophylaxis

_____ Fluoride treatment

_____Restorations

The following statements are applicable:
(Please check all that apply)

_____All necessary services have been performed

_____ No restorative services are required at this time

_____Further treatment is indicated

_____ Future appointments have been arranged

Comments:

_____ _____

Dentist's Signature **Date**