Racine Unified School District Office of Health Services

STUDENT HEALTH INFORMATION

(Please Print)

Student's Last Name: _____ First Name: _____ M.I. ___

Student's Home Address: _____ Phone: _____

DOB: _____ School: _____ Grade: _____

Student's Primary Doctor: _____ Clinic/Hospital: _____

Student's Health Information: **Check all that apply**

☐ My child is NOT being treated for any health problems at this time.

☐ My child may need medication at school. I need medication request forms. Yes ☐ No ☐

☐ My child is currently receiving services from a health care provider for the following: **Check all that apply**

- ☐ Hearing Problem
- ☐ Vision problem — Wears glasses — Yes ☐ No ☐
- ☐ Asthma — Uses a rescue inhaler — Yes ☐ No ☐
- ☐ Seizures
- ☐ Diabetes
- ☐ Allergies — Allergic to? _____
  _____
- ☐ Other (specify): _____
  _____

In Case of Medical Emergency:

- The student will be transported to the nearest emergency department.
- The parents or guardians are responsible for emergency medical treatment or expense.

Permission: I hereby give permission for:

- Emergency first aid treatment for my child.
- The school's principal or designee to call the physician named above if a medical emergency exists and I cannot be reached immediately.

- **My child's health information to be given to school district personnel who have an educational need to know it. I understand that my child's medical diagnoses will be disclosed. I understand that the Family Educational Rights and Privacy Act (FERPA) protects the confidentiality of this information with additional protection afforded by Wisconsin Statutes 118.25(2m) (a) (b) and 146.82-146.83.**

Signature Parent / Guardian _____ **Relationship:** _____

Date Signed: _____

CONFIDENTIAL – DO NOT DUPLICATE