



Waynesboro Area School District

210 Clayton Avenue
Waynesboro, PA 17268
717-762-1191

Student Health Information

Name of School Attending: _____ Today's Date _____

Student's Legal Name _____ Date of Birth _____ Female or Male
(circle one)

Parent/Guardian Name _____ Phone # _____

Parent/Guardian Name _____ Phone # _____

Name of child's Primary Doctor: _____

Address of child's Primary Doctor: _____

Phone of child's Primary Doctor: _____

Permission to speak with doctor (circle)? Yes/No Parent/Guardian Signature: _____

Please list all known allergies:

Food Allergies _____ Reaction _____

Bee Stings _____ Reaction _____

Animal/Plant _____ Reaction _____

Prescribed Treatments _____ Reaction _____

Medication _____ Reaction _____

Does your child have Asthma (circle)? Yes/No If Yes, (circle) is Nebulizer/Inhaler used?

Does your child wear corrective lenses (circle)? Yes/No Eye Surgery? _____

Does your child have a history of ear infections (circle)? Yes/No Frequency _____ Date of Last Occurrence _____

Date of Hearing Loss _____ Surgery? _____

Any complications during pregnancy or childbirth (circle)? Yes/No

If Yes, please explain: _____

Birth Weight: _____ Premature Birth? Yes/No Extended Hospitalization? Yes/No

Surgery/Hospitalization Reasons: _____ Date _____

Serious Accidents or Injuries: _____ Date _____

Seizure Disorder Type _____ Age at onset _____ Medication/Dose/Frequency _____

Is your child on Medication (circle)? Yes/No If Yes, list name/dosage/reason for each medication _____

Recurrent Illness or Condition (ADD/ADHD, Diabetes, Strep, Disability, Heart Murmur, Etc.): _____

Disclaimer: The School Nurse may share health condition information with appropriate school staff.