Northwest Education Services

Traverse City, Michigan
NorthwestEd.org

SCHOOL HEALTH RECORD

Student:_______________________________ Date of Birth:_________ Teacher:_________________________

Immunization History: **This information must be on file in the school office when your student enters the classroom program**.

☐ Immunization updates within the last year____

1. Has student had any serious infections or illness within the past year? Yes____ No ____ If yes, explain:
____

2. Has student had any injuries or accidents within the last year requiring medical attention? Yes____ No____ If yes, describe:____

3. Date of last physical examination: ___/___/___
Date of last dental examination: ___/___/___
Date of last eye/vision examination: ___/___/___ Wear glasses? Yes___ No ___ Contacts? Yes___ No ___
Date of last ear/hearing examination: ___/___/___ Results:__________ Hearing Loss? Yes ___ No ___

4. Has student had any medical tests in the past year? (Example: CT-Scan, EEG, MRI) Yes____ No ____ If yes, list dates and results: ____

5. Has student had any surgery within the past year? Yes____ No ____ If yes, describe:______________________________
____

6. Does student have any chronic health problems? (Example: asthma, diabetes) Yes___ No ___ If yes, describe:____

7. Does student experience seizures? Yes____ No ____ Last seizure date:_________________________
Date of most recent blood levels: ___/___/___

8. List any allergies/sensitivities:
- Food:____________________________________ Reaction: ____
- Medicine: ________________________________ Reaction: ____
- Environmental: ___________________________ Reaction: ____
- Insect Bites: ____________________________ __ Reaction: ____

Does student use Epi-Pen-Anakit? Yes____ No ____ If yes, where is it kept?______________________________

9. List ***ALL*** medications (including over-the-counter) that student takes and times administered in a 24-hour period. (list on reverse if needed).

Medication & Dose	Time

10. Is student on any type of special diet? Yes____ No ____ If yes, please describe:______________________________
____

11. List any serious illnesses or death of family member(s):____
____

12. Family Physician:____
Medical Specialist (pediatrician, psychiatrist, orthopedic, etc.) ____
____

13. Any concerns you may have regarding your student's health? ____
____

Signature:____
Relationship to student:_______________________________
Date:____

Program Nurses: Life Skills Center - Shannon Rice, R.N. (922-6219) email: srice@NorthwestEd.org
New Horizons – Kathy Hardies, R.N. (933-3570) email: khardies@NorthwestEd.org
Creekside School - Jay Barclay, R.N. (922-6209) email: jbarclay@NorthwestEd.org
Bridgeway - Michael Keim, R.N. (933-8675) email: mkeim@NorthwestEd.org