The Westview School
Health Services
2024-2025

HEALTH INVENTORY

Student Name: _____ Date of Birth: _____ / _____ / _____

Age: _____ Grade: _____ Teacher/Homeroom:_____

ATTENTION PARENT/ GUARDIAN: Please complete the first page of this form and have your child's physician complete the second page. Physician and Parent signatures are required and are located on the bottom of the second page. Please be aware that the information given on this form may be shared with appropriate school staff, so that we may best support your child. ***It is the responsibility of the parent/guardian to inform the School Nurse, in writing, of any changes in the student's health or medical status or to their medication list- this form is only completed upon first-time enrollment.***

This is your child's medical history only, not for other members of the family:

Disease History	Y	N	Disease History	Y	N	Disease History	Y	N
ADD/ ADHD			Cystic Fibrosis			Heart/ Cardiovascular		
Allergy to:			Depression			Hematologic/ Blood Disorders		
Arthritis			Dermatologic/ Skin			Immune System		
Asthma ***Submit Action Plan**			Diabetes			Muscular Dystrophy		
Autism Spectrum Disorder			Down Syndrome			Musculoskeletal		
Brain Injury			Ear/ Nose/ Throat			Psychosocial		
Cancer			Endocrine			Seizure Disorder ***Submit Action Plan**		
Cerebral Palsy			Gastrointestinal			Spina Bifida		
Chromosomal Abnormality			Headaches/ Migraines			Tracheostomy		

Please list any additional medical history: _____

If your child is under medical care for any of the above, please explain: _____

_____

Please list any surgical history: _____

Please list all medications: _____

_____

If your child will receive medication at school, a "Request for Administration of Medication at School" form will need to be submitted FOR EACH SCHOOL MEDICATION. All medications, prescription and non-prescription, MUST have physician authorization. Medications that have been ordered via an action plan (epinephrine, albuterol, diazepam, etc.) will not require this form, provided the action plan has been signed by both the provider and the parent.

Please list any special dietary needs: _____

Does your child have a **severe/ life-threatening** allergy, requiring immediate medical attention? **YES** **NO**

Please list the allergen and type of reaction your child has when exposed to allergen: _____

_____

Has this allergy been diagnosed by a healthcare provider? **YES** **NO**

Does your child have an Epi-Pen? **YES** **NO**

If you answered yes to any of the above, please submit an Allergy Action Plan with your Enrollment Packet.

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ATTENTION HEALTHCARE PROVIDER: Your patient has enrolled in our school. The parent/ guardian of the child must submit the most recent immunization record. If the child is unable to receive an immunization due to a medical condition, parents must submit a signed physician's statement. Please keep in mind that unless the statement specifies that a lifelong condition exists, the medical exemption statement is valid for one year from the date that the physician signed it.

Medication and special procedures may be administered to a child while at school, with written authorization from the child's physician and consent from the child's parent. Children with severe allergies, asthma, and/ or seizure disorders are required to have the respective Action Plan completed and signed by their physician. Parents have access to each of these forms through the Family Portal and should bring them to the child's appointment.

Care recommendations from a qualified specialist shall be required for any child with needs for special care due to a disability or limiting condition, prior to admission to The Westview School.

Please use the space provided below to indicate any medical exemptions from immunization(s), restrictions, or recommendations requiring special attention at school:

_____ has been examined by me and is physically able to participate in a school program.
(Student's Name)

_____ _____ _____
(Physician's Printed Name) (Physician's Signature) (Date of Exam)

_____ _____
(Physician's Address) (Physician's Phone)

_____ _____
(Parent/ Guardian Signature) (Date)