

**FOND DU LAC SCHOOL DISTRICT – SCHOOL HEALTH & SAFETY PROGRAMS**

72 W. Ninth Street, Fond du Lac, WI 54935

Telephone 920-906-6548 FAX 920-906-6563

**STUDENT HEALTH INFORMATION**

(to be completed by parent/guardian)

Date \_\_\_\_\_

Student's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age/Grade \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Address \_\_\_\_\_

School \_\_\_\_\_ Phone #1 \_\_\_\_\_ Phone #2 \_\_\_\_\_

Family Physician \_\_\_\_\_ Family Dentist \_\_\_\_\_

**HEALTH HISTORY**

1. Does your child have any health conditions? Yes\_\_\_ No\_\_\_  
(if so, please explain)

2. Does your child have allergies or food intolerance? Yes\_\_\_ No\_\_\_  
(if so, please explain)

3. Has your child experienced any serious illnesses, accidents, injuries, or surgeries? (if so, please explain) Yes\_\_\_ No\_\_\_

4. Is your child taking a daily medication? Yes\_\_\_ No\_\_\_  
(if so, list medication(s) and reason(s))

5. Is your child taking PRN (as needed) medication? Yes\_\_\_ No\_\_\_  
(if so, list medication(s) and reasons(s))

6. Do you have any concerns about your child's behavior? Yes\_\_\_ No\_\_\_  
(if so, please explain)

**DEVELOPMENTAL HISTORY**

Do you have any concerns about your child's growth or development? Yes\_\_\_ No\_\_\_  
(if so, please explain)

**VISION HISTORY**

Has your child experienced any difficulties with vision? Yes\_\_\_ No\_\_\_

Has your child ever had a professional vision exam? Yes\_\_\_ No\_\_\_ Doctor:\_\_\_\_\_

Date\_\_\_\_\_ Results\_\_\_\_\_

**HEARING HISTORY**

Has your child been treated medically or surgically for ear problems or frequent ear infections? Yes\_\_\_ No\_\_\_

Was your child treated by an ear specialist? Yes\_\_\_ No\_\_\_

Name of specialist\_\_\_\_\_

Hearing results\_\_\_\_\_

**SPEECH**

Do you think your child’s speech and language development is appropriate for his/her age? Yes\_\_\_ No\_\_\_

**Is there any information about your child that would be helpful to school personnel in working with your child?**

The above information is accurate and complete and may be used by school district personnel for educational purposes of my child.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Please remember to complete and return the yellow immunization card.**