Elkhorn Area School District
High School Student Health Update Form

NAME_____ Grade_____ Date_____
Family Physician_____ Family Dentist _____
Last visit to physician?_____ Last visit to dentist: _____

Ninth Grade and New Students:

1. Is the recommended physical completed? Yes, completed and turned in to office_____. No, physical is scheduled for_____(date). Please note the WIAA requires a current physical for all high school students participating in after-school activities.
2. Is the recommended dental check completed? Yes, completed and turned in to office ____ No, dental check is scheduled for _____(date).

All Students:

1. Last eye exam was on what date? _____. Glasses? Yes No Contacts? Yes No
2. Does your child take any medication? No ___ If yes, __at home __at school. Please state medication and explain medication use: _____
3. Does your child have a vision or hearing concern that requires seating adjustments? No ___ If yes, explain_____. Is your doctor aware? Yes_____No _____
4. Has your child been diagnosed with a health concern that would require staff to make classroom accommodations to help your child succeed in school such as ADD/ADHD, depression, diabetes, epilepsy, a heart condition, anxiety, joint or bone pain, or other physical or mental condition? No ___ If yes, explain: _____
5. If your child has asthma. Have they ever used an inhaler?_____
6. Has your child been hospitalized in the last year? No____ If yes, please explain why the child was hospitalized: _____
7. Is your child current in the State of Wisconsin required immunizations? Yes____, No____. Please note students who are not in compliance with required immunizations may be excluded from school.
8. Has your child had any major life changes in the past year such as deployment, moving, death, imprisonment of a family member or loved one, divorce of parents, traumatic accident or any life event that has produced a change in your child's performance, behavior or outlook on life? No___If yes, explain _____
9. Has your child been seen by a mental health professional or a counselor (other than the school guidance counselor) in the past year? No ___ If yes, explain _____
10. Does your child have any concerns or behaviors that the school should be made aware of? No___ If yes, explain_____
11. Do you know of any physical or mental concerns that prevent your child from *fully participating* in all school activities: No __ If yes, explain _____
    Please note that a doctor's excuse is required if your child is not able to fully participate.
12. Additional comments that you would like the school to know: _____
    _____
13. Would you like a school counselor to contact you with your concerns? No____ Yes____. Please provide the best way and time to reach you: _____

The above health information can be shared between the health care provider(s) listed and appropriate school personnel to promote a healthy and successful school experience.

Parent(s) or Guardian(s) Signature _____ Date _____