

**Black Hawk School District Health Form**

Student LEGAL Name \_\_\_\_\_ Birth Date \_\_\_\_\_

CHECK HERE IF NOT A NEW STUDENT AND NO UPDATES \_\_\_\_\_

**Please fill out completely if new student, or returning student.**

**Care Team Information:**

Primary Physician \_\_\_\_\_ Last visit \_\_\_\_\_  
Physician phone number \_\_\_\_\_

Dentist \_\_\_\_\_ Last visit \_\_\_\_\_  
Phone \_\_\_\_\_

Last Eye Exam \_\_\_\_\_ Glasses? \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

Does your student have significant health problems (things they see a doctor for regularly, take medications, or other issues) we should know about? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list **ALL MEDICATIONS** your student takes at home, and school. (please complete medication authorization form for medications to take at school)  
\_\_\_\_\_  
\_\_\_\_\_

Does your student have **SEVERE ALLERGIES** requiring epinephrine? If yes, what?  
\_\_\_\_\_  
\_\_\_\_\_

Does your student have **MEDICATION OR FOOD ALLERGIES**? If yes- please list allergen and reaction \_\_\_\_\_  
\_\_\_\_\_

(over)

Is your student a Badger-Care or Public Aid recipient? \_\_\_\_\_

Does your family have adequate access/funds for food? \_\_\_\_\_  
if not, would you be interested in participating in the Warrior Backpack Program?

Is your student: Fully immunized? \_\_\_\_\_  
Partially immunized \_\_\_\_\_  
We have stopped immunizing completely \_\_\_\_\_  
We are following a delayed schedule \_\_\_\_\_  
We are behind, but plan to catch up \_\_\_\_\_  
No immunizations \_\_\_\_\_

*\*\*Please see enclosed required immunizations for the State of Wisconsin\*\**

Is there anything else you would like us to know about your student?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Guardian Name \_\_\_\_\_