Health Services Department
200 E 800 S, Heber City, UT 84032
Email: health.services@wasatch.edu
Phone: (435) 654-0280 x4144
Fax: (435) 200-1032

Student Health Evaluation Intake Form

Student Name:	DOB:
Parent/Guardian's Name:	Phone Number:
School:	Secondary Phone Number:
Health Care Provider:	Health Care Provider:
Phone:	Phone:
Preferred Hospital:	

MEDICATIONS

☐	Student needs medications administered during school hours	List of medications & dosages:			
☐	Medications received at home	List of medications & dosages:			
☐	Medication History:				
☐	Health care providers orders for medication at school already completed	Yes	☐	No	☐
☐	No concerns at this time				

ALLERGIES

☐	Anaphylactic	☐	Food	☐	Other allergen:	☐	Epipen at school
☐	Not anaphylactic	☐	Seasonal	☐	Other medications at school for allergies		
☐	Describe:						
☐	No Concerns at This Time						

RESPIRATORY

☐	Asthma	☐	Seasonal	☐	Exercise induced	☐	Viral
☐	Inhaler at home	☐	Inhaler at school	☐	Not currently using an inhaler		
☐	Other: (Example: Cystic Fibrosis, Oxygen Therapy etc.)						
☐	No concerns at this time						

CARDIAC

☐	Diagnosis:
☐	History:
☐	Restrictions: (Example: Long QT Syndrome, Wolff Parkinson White Syndrome etc.)
☐	No concerns at this time

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NEUROLOGICAL

☐	ADHD/Inattentive/Combined:
☐	Autism
☐	Seizures Type (Example: Shunt, Vagal Nerve Stimulator etc.)
☐	Traumatic Brain Injury (TBI) Date: Description of event:
☐	Other:
☐	No concerns at this time

ENDOCRINE

☐	Diabetes	☐	Type 1	☐	Type 2 Date Diagnosed:
☐	Other: (Example: Thyroid Disease, Addison's Disease etc.)				
☐	No concerns at this time				

GASTROINTESTINAL

☐	Tube feeding
☐	Special dietary needs:
☐	Assisted oral feedings
☐	At risk for aspiration
☐	Other: (Example: Anorexia, Bulimia, Crohn's Disease, etc.)
☐	No concerns at this time

GENITOURINARY

☐	Toilet trained
☐	Diapered during school day
☐	Needs toileting assistance at school
☐	Other: (Example: Reproductive Concerns, Chronic Urinary Tract Infections, etc.)
☐	No concerns at this time

MUSCULOSKELETAL

☐	Special equipment needs	☐	Lift	☐	Walker	☐	Braces
☐	Wheelchair	☐	Helmet				
☐	Unstable ambulation						
☐	Safety concerns						
☐	Positioning						
☐	Other: (Example: Muscular Dystrophy, Paralysis etc.)						
☐	No concerns at this time						

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SENSORY

☐	Hearing concerns	☐	Hearing aids	☐	Currently using an FM system
☐	Vision concerns	☐	Glasses	☐	Contact lenses
☐	Non-verbal				
☐	Alternate communication device				
☐	Sign language				
☐	Language interpreter				
☐	Sensory processing disorder				
☐	Other: (Example: Asperger's, Autism, Pervasive Developmental Delays)				
☐	No concerns at this time				

MENTAL HEALTH

☐	Anxiety
☐	Bipolar
☐	Depression
☐	Obsessive Compulsive Disorder
☐	Other
☐	No Concerns at This Time

OTHER CONCERNS

☐	

PARENT AUTHORIZATION

As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to perform and carry out the tasks as outlined in this health care plan and for the child's healthcare provider to share information with the school nurse for the completion of this plan. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the school nurse whenever there is any change in the student's health status or care. Parents/Guardians are responsible for maintaining necessary supplies, medications, and equipment.

Parent Signature: ____ **Date:** ________________

WCSD STAFF USE ONLY

Date of Review:
Reviewed by *(WCSD Health Professional):*
Signature: