

Portage Community School District

Annual Student Health Update

School Year: 2025-2026

My child attends PreK at (CIRCLE): Portage Prodigies Program

Alphabet Express Head Start Little School Learning Tree St. John's St. Mary's

Student's Name _____ Birthdate _____ Grade PreK or Early Childhood

Does your child have any of the following as **diagnosed by a physician**? (Please circle YES or NO) _____ NONE TO ALL

Yes	No	Asthma: Present ____ In past ____	Yes	No	Insect Sting Allergy
		Inhaler needed at school? ____			Insect:
Yes	No	Diabetes: Type 1 or Type 2 (circle)			Reaction:
Yes	No	Heart Concern:			Treatment:
Yes	No	Cancer: Type	Yes	No	Allergy to Medication
Yes	No	High Blood Pressure			List:
Yes	No	Rheumatoid Arthritis			
Yes	No	Bleeding Concern:	Yes	No	Food Allergies (Severity/Specifics)
Yes	No	Seizure Disorder: Type			Food:
		Last Seizure:			Reaction:
Yes	No	Migraine or Other Headaches			Mild / Moderate / Severe – circle one
Yes	No	Scoliosis			Treatment:
Yes	No	Vision Issue? Wears Glasses or Contacts (circle)	Yes	No	Seasonal/Other Allergies
Yes	No	Hearing Issue? Hearing Aid ____ R ____ L			List:
Yes	No	Attention Deficit Hyperactivity Disorder			
		(ADHD)/Attention Deficit Disorder (ADD)	Yes	No	Operations or Surgeries
		Treatment:			List:
Yes	No	Depression	Yes	No	Mobility Concerns
Yes	No	Anxiety			List:
Yes	No	Organ Transplant	Yes	No	Developmental or Other Health Diagnosis
		Organ(s):			List:

IF YOUR CHILD HAS A DIAGNOSED MEDICAL CONDITION - PLEASE CONTACT THE DISTRICT

NURSE: VALERIE HON, RN AT 608-742-4879 ext. 4022

Child's Physician: _____ Clinic number: _____

Dentist: _____ Clinic number: _____

My child is covered by health insurance: Yes No (Circle one)

Please list the medications that your child is taking (i.e., inhalers, insulin, antidepressants, etc.)

	Medication Name	Dose	Time Taken	Purpose
1				
2				
3				
4				
5				
6				

If your child needs to take medication during PreK school hours, the parent/guardian must complete a Medication Request/Consent Form. **Prescription medications and some non-prescription medications require a doctor's signature.** Forms can be obtained from the District Registrar or online. Students **are not allowed** to carry medications with them unless it has been approved by both the physician and parent (i.e., inhaler, Epi-pens, glucagon). Questions may be directed to the school nurse.

The Portage School District Nurse will work with PreK staff to complete the medication training required by Wisconsin Statutes.

*The above information is correct to the best of my knowledge. Should changes occur, I will notify the school nurse to ensure appropriate understanding of my child's health status. This information will be shared with appropriate preschool staff to assure a safe environment for my child.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Print _____ Telephone number _____

Student's name: _____

Birthdate: _____

Developmental History

1. Birth and Infancy: Birth weight _____ Full term _____ Premature _____ Overdue _____

2. Any problems with pregnancy or delivery? Yes _____ No _____

Explain: _____

3. Age at which child: Crept _____ Walked _____ Said first word _____ Said first sentence _____

4. Any speech concerns? Yes _____ No _____

Explain: _____

5. Any bedtime or sleep concerns? Yes _____ No _____

Explain: _____

6. Describe your child's appetite.

7. How would you describe your child's activity level? Overactive _____ Under-active _____ Normal activity _____

Explain: _____

8. Does your child have any vision or hearing concerns? Yes _____ No _____

Explain: _____

9. What services has your child received through other agencies?

10. Has your child experienced any traumatic or upsetting experiences? Yes _____ No _____

Explain: _____
