Wayne County Health Department

203 E Main Street

Richmond, In 47374

Walk-In Evaluation

Date:_____

Person being evaluated:_____DOB_____Age_____

Reason for visit_____

Allergies:_____ Pharmacy:_____

Do you have a history of seizures? Yes___ No___ Insurance Name_____

Are you pregnant? Yes_____ No_____

Name Family/Household Members	DOB	ALLERGIES	SEIZURE DISORDER	PREGNANT

What school do you attend? (if under 18 years of age) _____

_____

FOR OFFICE USE ONLY

Live lice: Yes_____ No_____ Nits: Yes_____ No _____

Treatment:_____

_____

Nurse:_____