



STUDENT HEALTH HISTORY FORM

Updated 10/24/2018

Parent/Guardian, please complete:

SCHOOL YEAR: _____

Name of Student: _____

School: _____ Grade: _____ Date of Birth: _____

NAME OF CHILD'S DOCTOR/ NURSE PRACTITIONER _____ phone _____

LIFE THREATENING MEDICAL CONDITIONS: WA state law requires a medication/treatment order from a Health Care Provider if your child's health condition will *put your child in danger of death during the school day*. Written orders /information must be received by the School Nurse before your child can attend school. If appropriate, a care plan will be developed with the school nurse and parent/guardian.

DOES YOUR CHILD HAVE A LIFE THREATENING HEALTH CONDITION? YES NO

If Yes, Please describe: _____

YES NO **Severe Allergic Reaction (Bee Stings, Nuts, Shellfish, etc.):** Anaphylaxis YES NO
DESCRIBE: _____

YES NO **OTHER Allergic Reactions** Describe: _____

YES NO **Asthma** Will your child require asthma medication during school hours? YES NO
Last Asthma episode requiring medical attention: _____

YES NO **Diabetes** TYPE: _____ SELF MANAGE: YES NO PUMP: YES NO

YES NO **Heart Condition** Describe: _____

YES NO **Nosebleeds** Frequency: _____

YES NO **Orthopedic Condition** Describe: _____

YES NO **Seizure/Neurological Disorder** Describe: _____
Last episode requiring medical attention: _____

YES NO **Migraines** Describe: _____

YES NO **Bowel/Bladder Condition** Describe: _____

YES NO **GI/Feeding Condition** Describe: _____

YES NO **Behavioral/Emotional Concerns** Describe: _____

YES NO **Vision Issues/Concerns** Describe: _____ Glasses: YES NO Contacts: YES NO

Approximate date of last eye exam _____

YES NO **Hearing Issues/Concerns** Describe: _____ Hearing Aids: YES NO
Approximate date of last hearing exam _____

YES NO **Speech/Language Issues/Concerns** Describe: _____

YES NO **Other Health Concerns** Describe: _____

YES NO **Does your child have any other conditions that would affect classroom performance or P.E. activities?**
If yes, please explain: _____

DAILY MEDICATION:

State law requires **written authorization from a Health Care Provider and parent** before **any** medication can be given at school.
Medication forms are available at school or online.

YES NO **Medication needed at school (Specify):** _____ (Authorization Needed)

YES NO **Medication taken at home (Specify):** _____

This information is considered confidential. To ensure the health and safety of your child, it will be shared with school staff on a need to know basis. You agree to bring to the attention of the school any MAJOR CHANGES in the health of your student. You further give permission for South Whidbey School District staff to seek emergency medical services if necessary and to contact your child's healthcare provider and / or health department to access Immunization records.

Parent/Guardian (Printed Name): _____

Parent/Guardian Signature: _____

Telephone: (Home) _____ (Cell) _____ (Work) _____