



Northshore School District

3330 Monte Villa Pkwy  
Bothell, WA 98021

Health Services

HEALTH REGISTRATION FORM

Student Name \_\_\_\_\_ Grade \_\_\_\_\_ Birthdate \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Medical Insurance  Yes  No

The following information is considered confidential and is for the use of teachers, principal, school nurse, or other staff who will be in contact with and responsible for your child during the school day. Please contact your School Nurse if you prefer to discuss the following statements personally.

MY CHILD HAS A LIFE THREATENING CONDITION  Yes  No

If YES, Washington State law requires that medication or treatment orders and a health care plan be in place prior to the start of school. Students with a Life Threatening Condition will have an Emergency Care Plan, as qualified for under Section 504 of the Rehabilitation Act. The school nurse will develop the plan with input from the parents, health care provider and other school staff as needed prior to school attendance. Your signature on this form grants permission to initiate this process.

Allergies  None OR  Plants  Foods  Bees / Insects  Animals  Other

Please describe reaction \_\_\_\_\_

Asthma  No  Yes Provoked by \_\_\_\_\_

	NO	YES	EXPLAIN
Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Health (e.g. depression / anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	_____
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bone, Joint, Muscle Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Stomach/Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Problems (glasses / contacts)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Does the student take medication of any kind?  None OR  Home  School Explain: \_\_\_\_\_

Students requiring medication (prescription or non-prescription) at school must have a written physician order and written parent consent. **ALL Medication Orders must be renewed EACH SCHOOL YEAR.**

Forms are available in the school office or [www.nsd.org](http://www.nsd.org)

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_