RICHLAND School District

615 Snow Avenue, Richland, WA 99352

Student Health History Form

Parent/guardian, please complete: Name of Student: _____

School: _____ Grade: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

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 must be received by the School Nurse, and if appropriate, a care plan must be in place **before your child can attend school**.

✓ Does your child have a LIFE THREATENING HEALTH CONDITION? ☐ No ☐ Yes

If yes, please state condition:

☐ No ☐ Yes **Severe Allergic reaction to Bee Sting. Anaphylactic ☐ No ☐ Yes Describe:** _____

☐ No ☐ Yes **Severe Allergic reaction to Food or Nuts.** Type: _____ **Anaphylactic ☐ No ☐ Yes**
Describe _____

☐ No ☐ Yes **Mild Allergic reaction to Food or Nuts.** Type: _____ Reaction: _____

☐ No ☐ Yes ***Other* Allergic Reactions.** Type: _____ Reaction: _____

☐ No ☐ Yes **Asthma. Will your child require asthma medication during school hours? ☐ No ☐ Yes**

☐ No ☐ Yes **Diabetes.** Type: _____ Self manage: _____ **Pump: ☐ No ☐ Yes**

☐ No ☐ Yes **Heart Condition.** Diagnosis: _____ **Pacemaker: ☐ No ☐ Yes**

☐ No ☐Yes **Bleeding Disorder.** Diagnosis: _____

☐ No ☐ Yes **Orthopedic Condition.** Diagnosis: _____

☐ No ☐ Yes **Seizure/Neurological Disorder.** Describe: _____

☐ No ☐Yes **GI/Feeding condition**. Describe: _____

☐ No ☐Yes **Bowel/Bladder condition**. Describe: _____

☐ No ☐ Yes **Other Health Concerns:** _____

☐ No ☐Yes **Does your child have any other condition that would affect classroom performance or P.E. activities?**
If yes, please explain: _____

☐ No ☐ Yes **Behavioral/Emotional Concerns:** _____

☐ No ☐ Yes **Glasses:** _____ **Contacts:** _____ Reason: _____ Date of last eye exam: _____

☐ No ☐ Yes **Hearing Impairment:** _____ Date of last hearing exam: _____ **Hearing Aids: ☐ No ☐ Yes**

☐ No ☐ Yes **Health Insurance: Name** _____

☐ No ☐ Yes **Primary Care Provider (Doctor/ARNP/PA)** _____

Daily Medications:

State law requires ***written authorization from a Health Care Provider and parent*** before **any** medication, prescription or over-the-counter, can be given at school. Medication forms are available online at www.rsd.edu.

☐ No ☐ Yes **Medication needed at school:** (specify): _____ (Authorization needed)

☐ No ☐ Yes **Medication needed at home:** (specify): _____

Parent/Guardian (Printed Name): _____

Parent/guardian signature: _____ **Date** _____

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

This information is considered confidential. To ensure the health and safety of your child, it will be shared with school staff as needed during the time your child is enrolled in Richland School District, unless you request otherwise in writing.