Washington State Department of CHILDREN, YOUTH & FAMILIES

KENNEWICK SCHOOL DISTRICT
Education is the bridge to the future.

Student Health History

To be completed by parent/guardian

Students Name: ______________________________ Date of Birth: __________

Sex: ☐Male ☐Female

☐ No ☐ Yes Glasses/Contacts, Date of last eye evaluation: ____

☐ No ☐ Yes Hearing Aids, Date of last hearing exam: ____

Daily Medications

State law requires written permission from a Health Care Provider and parent before any medication (prescription or over-the-counter) can be given at school. A form is available from the school office.

☐ No ☐ Yes Medication needed at school (list): ____

☐ No ☐ Yes Medication needed at home (list): ____

Life Threatening or Chronic Health Conditions

Washington State law mandates that students with life-threatening health conditions, where the condition would "put the child in danger of death during the school day", have medication/treatment orders and an Individual Health Plan in place at school **before** your child can attend school.

Life Threatening Conditions (WILL require Health Care Provider orders)

Please check all that apply:

* Severe allergy means diagnosed by a Health Care Provider and medication, such as an EpiPen has been prescribed.

☐ No ☐ Yes Severe allergic reaction to nuts (list): ______________________________ EpiPen ☐ Yes ☐ No

☐ No ☐ Yes Severe allergic reaction to bee stings? EpiPen ☐ Yes ☐ No

☐ No ☐ Yes other severe allergies – affecting school? Specify: ____________________ EpiPen ☐ Yes ☐ No

☐ No ☐ Yes Severe Asthma? Regularly takes medication for asthmatic condition or hospitalized within last 5 years for Asthmatic condition.

☐ No ☐ Yes Diabetes?

☐ No ☐ Yes Other? ____

Chronic Health Conditions (MAY require Health Care Provider orders)

Please check all that apply and explain:

☐ No ☐ Yes Asthma? Takes medication only when needed.

☐ No ☐ Yes Seizure Disorder?

Types of seizures and date of last seizure: ____

☐ No ☐ Yes Heart Condition? ____

☐ No ☐ Yes Behavioral/Emotional concerns? ____

☐ No ☐ Yes Orthopedic conditions? ____

☐ No ☐ Yes other health concerns? ____

Does your child have any other condition that would affect his/her classroom performance or outdoor activities?

☐ No ☐ Yes If yes, explain:

____

____

____

Health:

☐ No ☐ Yes Were you told that your child was born early or premature? How early? ____________

☐ No ☐ Yes Were there significant complications during pregnancy?

☐ No ☐ Yes Were drugs, alcohol or cigarettes part of family life during pregnancy?

List any Drugs/Alcohol/Medications used during pregnancy?

____

☐ No ☐ Yes Has your child had any serious illnesses, injuries, surgeries or seen a specialist?

If YES what/when: ____

☐ No ☐ Yes Does your child take a prescribed fluoride supplement?

Nutrition:

☐ No ☐ Yes Does your child have any food allergies? ____________________________________

☐ No ☐ Yes Does your child have a lactose intolerance?

☐ No ☐ Yes Does your child have a special diet? If Yes what? ___________________________

☐ No ☐ Yes Do you avoid feeding your child certain foods for personal or religious reasons?

If Yes what? ____

Emotional Health:

Please explain any major changes in your child's life (i.e. birth of a sibling, death in the family, divorce) in the past year.

____

____

Parent Information:

☐ No ☐ Yes Is there any accommodations or assistance your child needs in the classroom? (Adaptive equipment?)

____

Is there any additional information you think ECEAP staff might need to know about your child's health?

____

____

____

Parent/Guardian Signature: ____**Date:** ________________

This information is considered confidential. It will be shared with school staff as needed during the time your child is enrolled in the Kennewick School District in order to ensure the health and safety of your child, unless otherwise requested by you in writing.