STUDENT HEALTH RECORD

Northshore School District

Student Name: (Last)_____(First)_____**Birthdate:**_____

Parent/Guardian Name:_____**Phone 1:**_____**Phone 2:**_____

*State law requires that students with life-threatening conditions such as anaphylaxis, severe asthma, diabetes or seizures have a care plan completed **prior to the first day of school**. Contact the school nurse as soon as possible to complete the proper forms.*

Does your student have a LIFE-THREATENING health condition? ☐ Yes ☐ No

MEDICAL HISTORY (check all that apply)

Life-Threatening Conditions: (Care plan is REQUIRED)

- ☐ **Anaphylaxis (Epi-pen prescribed)**
  Allergen/s:
- ☐ **Diabetes Type 1**
- ☐ **Seizures – (Emergency medication required)**
- ☐ **Asthma – Severe**
- ☐ **Other Life-Threatening Condition:**

Congenital / Genetic

- ☐ Down Syndrome
- ☐ Fetal Alcohol Spectrum Disorder
- ☐ Please list:

Blood / Hematology

- ☐ Anemia
- ☐ Hemophilia
- ☐ Sickle Cell ☐ Disease ☐ Trait
- ☐ History of Severe Nosebleeds
- ☐ Other Blood Condition:

Cardiac / Heart

- ☐ Heart Birth Defect
- ☐ Heart Murmur
- ☐ Other Cardiovascular Condition:

Allergy, Immune, Endocrine, Metabolic and Nutritional

- ☐ Allergy – Food
- ☐ Allergy – Insect
- ☐ Allergy – Other - List:
- ☐ Diabetes Type 2
- ☐ Other Endocrine, Immune, Nutritional or Metabolic:

Gastrointestinal, Dental and Oral

- ☐ Celiac
- ☐ Food Intolerance - List:
- ☐ Lactose Intolerance
- ☐ Encopresis
- ☐ Chronic Constipation
- ☐ Gastric Reflux
- ☐ Inflammatory Bowel Disease
- ☐ Irritable Bowel Syndrome
- ☐ Other Gastrointestinal, Liver, Dental, Oral Condition

Musculoskeletal

- ☐ Juvenile Rheumatoid / Idiopathic Arthritis
- ☐ Please list:

Cancer / Tumor

- ☐ Please list:

Nervous System

- ☐ ADHD / ADD diagnosed by:
- ☐ Autism Spectrum Disorder
- ☐ Cerebral Palsy
- ☐ Developmental Disability
- ☐ Migraines
- ☐ Headaches, Recurring
- ☐ Seizure Disorder ☐ Current ☐ History Type:
- ☐ Traumatic Brain Injury
- ☐ Other Neurological Condition:

Transplant

- ☐ List organ:

Mental or Behavioral Health

- ☐ Anxiety
- ☐ Depression
- ☐ Sleep Disorder
- ☐ Other Mental or Behavioral Health Condition

Respiratory / Breathing

- ☐ Asthma – Current
- ☐ Asthma – Ever Diagnosed
- ☐ Asthma – Exercise Induced
- ☐ Reactive Airway Disease
- ☐ Other Respiratory Condition:

Skin

- ☐ Eczema or Contact Dermatitis or Psoriasis
- ☐ Other Skin Condition:

Renal / Kidney

- ☐ Please list:

Ear / Hearing

- ☐ Chronic Ear Infections ☐ Currently ☐ Historically
- ☐ Hearing Impaired Hearing Aid/s Cochlear Implant
- ☐ Other Ear Condition:

Eye / Vision

- ☐ Wears glasses / contacts
- ☐ Color Vision Deficit
- ☐ Visually Impaired
- ☐ Other Eye Condition:

Other Health Concerns:

- ☐ Please list:

☐ No known health concerns **Please initial** _____

STUDENT HEALTH RECORD

Northshore School District

Student Name: (Last)_____**(First)** _____ **Birthdate:** _____

MEDICATIONS

Please report all medications that your student takes at home and/or at school.

Is medication needed at home?	☐ No	☐ Yes	Please list:
Is medication needed at school? **Complete REQUIRED paperwork for medication at school.**	☐ No	☐ Yes	Please list:

State law requires written permission from guardian and a health care provider before any medication (prescription and over-the-counter) may be taken at school. Forms are available from your school office or on our district website and must be completed annually.

Medical Devices

- ☐ Vagal Nerve Stimulator
- ☐ Automatic Internal Cardiac Defibrillator
- ☐ Pacemaker
- ☐ Gastrostomy tube
- ☐ Jejunostomy tube
- ☐ Brace
- ☐ Prosthesis List:
- ☐ Other medical devices:

Stoma

- ☐ Gastrostomy
- ☐ Colostomy
- ☐ Tracheostomy
- ☐ Urostomy
- ☐ Other:

Physical Activity / Mobility Issues:

- ☐ Wheelchair
- ☐ Crutches
- ☐ Other - List:

I understand that the information I provided will be shared with appropriate school staff who need to know in order to provide for the health and safety of my student. If parents/guardians or authorized emergency contacts cannot be reached at the time of a medical emergency, and if immediate care is urgent in the judgement of school authorities, I authorize and direct the school authorities to send the student to the hospital or healthcare provider most easily accessible. I understand that I will assume full responsibility for the payment of any services rendered. **I understand that Washington law requires that my student's immunizations are complete or conditional before starting school.** I give permission to my child's school to add immunization information to the Immunization Information System to help the school maintain my child's school record.

Parent/Legal Guardian Signature: _____ **Date:** _____

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IMMUNIZATION VERIFICATION (Office use only)

WAIIS # _____ CIS Series: ☐ Preschool ☐ Grade K-6 ☐ Grade 7 ☐ Grade 8-12

☐ Immunization Status is COMPLETE on the WAIIS Certificate of Immunization Status (CIS).

OR

☐ Immunization Status is CONDITIONAL on the WAIIS CIS and the conditional status expiration date is after the first day of attendance.

☐ Parent/Guardian has signed the conditional status acknowledgement on the CIS.

OR

☐ Student is not in WAIIS. **Medically verified immunization records must be provided.**

☐ Medically verified immunization records provided ☐ Permission to enter statement signed

OR

☐ Certificate of Exemption (COE) provided for all vaccines not in compliance on WAIIS CIS or in WAIIS.

☐ COE is fully completed ☐ Permission to enter statement signed

OR

☐ Immunization Status is NOT COMPLETE on the WAIIS CIS **Student may not start school until documentation of missing immunizations is received that will change the CIS status to COMPLETE or CONDITIONAL.**

☐ Student added to School Module Roster: Grade: _____

Staff who verified immunizations: _____ Date: _____