



STUDENT HEALTH RECORD

Student Name, Last: _____ First: _____ Birthdate: _____ Grade: _____

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

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.

MEDICAL HISTORY (check all that apply)

<p>Life-Threatening Conditions: (Care plan is REQUIRED)</p> <input type="checkbox"/> Anaphylaxis (Epinephrine prescribed), List Allergen/s: _____ <input type="checkbox"/> Diabetes Type 1 <input type="checkbox"/> Seizures – (Emergency medication required) <input type="checkbox"/> Asthma – Severe <input type="checkbox"/> Other Life-Threatening Condition: _____	<p>Nervous System</p> <input type="checkbox"/> ADHD <input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Migraines <input type="checkbox"/> Headaches, Recurring <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Current <input type="checkbox"/> History Type: _____ <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Other Neurological Condition: _____
<p>Congenital / Genetic</p> <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Fetal Alcohol Spectrum Disorder <input type="checkbox"/> Other Congenital / Genetic: _____	<p>Transplant</p> <input type="checkbox"/> List Organ: _____
<p>Blood / Hematology</p> <input type="checkbox"/> Anemia <input type="checkbox"/> Hemophilia <input type="checkbox"/> Sickle Cell: <input type="checkbox"/> Disease <input type="checkbox"/> Trait <input type="checkbox"/> History of Severe Nosebleeds <input type="checkbox"/> Other Blood Condition: _____	<p>Mental or Behavioral Health</p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Sleep Disorder <input type="checkbox"/> Other Mental or Behavioral Health Condition: _____
<p>Cardiac / Heart</p> <input type="checkbox"/> Heart Birth Defect <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Other Cardiovascular Condition: _____	<p>Respiratory / Breathing</p> <input type="checkbox"/> Asthma – Current <input type="checkbox"/> Asthma – Ever Diagnosed <input type="checkbox"/> Asthma – Exercised Induced <input type="checkbox"/> Reactive Airway Disease <input type="checkbox"/> Other Respiratory Condition: _____
<p>Allergy, Immune, Endocrine, Metabolic and Nutritional</p> <input type="checkbox"/> Allergy – Food, List: _____ <input type="checkbox"/> Allergy – Insect: _____ <input type="checkbox"/> Allergy – Other List: _____ <input type="checkbox"/> Diabetes Type 2 <input type="checkbox"/> Food Restriction: _____ <input type="checkbox"/> Other Endocrine, Immune, Nutritional or Metabolic: _____	<p>Skin</p> <input type="checkbox"/> Eczema <input type="checkbox"/> Contact Dermatitis <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other Skin Condition: _____
<p>Gastrointestinal, Dental and Oral</p> <input type="checkbox"/> Celiac <input type="checkbox"/> Food Intolerance, List: _____ <input type="checkbox"/> Lactose Intolerance <input type="checkbox"/> Encopresis <input type="checkbox"/> Chronic Constipation <input type="checkbox"/> Gastric Reflux <input type="checkbox"/> Inflammatory Bowel Disease: _____ <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Other Gastrointestinal, Liver, Dental, Oral Condition: _____	<p>Renal / Kidney</p> <input type="checkbox"/> Please List: _____
<p>Musculoskeletal</p> <input type="checkbox"/> Juvenile Rheumatoid / Idiopathic Arthritis <input type="checkbox"/> Other Musculoskeletal: _____	<p>Ear / Hearing – please note L or R for left or right</p> <input type="checkbox"/> Chronic Ear Infections <input type="checkbox"/> Currently <input type="checkbox"/> Historically <input type="checkbox"/> Hearing Impaired: _____ <input type="checkbox"/> Hearing Aid/s _____ <input type="checkbox"/> Cochlear Implant _____ <input type="checkbox"/> Other Ear Condition: _____
<p>Cancer / Tumor</p> <input type="checkbox"/> Please List: _____	<p>Eye / Vision</p> <input type="checkbox"/> Wears Glasses <input type="checkbox"/> Wears Contacts <input type="checkbox"/> Color Vision Deficit <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Other Eye Condition: _____
	<p>Other Health Concerns or Information</p> <input type="checkbox"/>

No known health concerns

Please initial _____

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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? <input type="checkbox"/> No <input type="checkbox"/> Yes Please List: _____
Is medication needed at school? <input type="checkbox"/> No <input type="checkbox"/> Yes Please List: _____ Complete REQUIRED paperwork for medication at school.
<i>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.</i>

Medical Devices <input type="checkbox"/> Vagal Nerve Stimulator <input type="checkbox"/> Automatic Internal Cardiac Defibrillator <input type="checkbox"/> Pacemaker <input type="checkbox"/> Gastrostomy tube <input type="checkbox"/> Jejunostomy tube <input type="checkbox"/> Brace <input type="checkbox"/> Prosthesis, List: _____ <input type="checkbox"/> Other Medical Devices, List: _____	Stoma <input type="checkbox"/> Gastrostomy <input type="checkbox"/> Colostomy <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Urostomy <input type="checkbox"/> Other, List: _____ Physical Activity / Mobility Issues: <input type="checkbox"/> Wheelchair <input type="checkbox"/> Crutches <input type="checkbox"/> Other, List: _____
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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: _____

FOR OFFICE USE ONLY

IMMUNIZATION VERIFICATION

WAIS # _____ CIS Series: Preschool Grade K-6 Grade 7-8 Grade 9-12

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

OR

Immunization Status is CONDITIONAL on the WAIS 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 WAIS. **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 WAIS CIS or in WAIS.

COE is fully completed Permission to enter statement signed

OR

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

Staff who verified immunizations: _____ Date: _____