South Kitsap School District

2023-24 HEALTH HISTORY AND CONDITIONS FORM

DATE: _____ SCHOOL: _____ GRADE: _____

STUDENT NAME: _____ GENDER: _____ BIRTHDATE: _____

Indicate below the medical conditions which are <u>SEVERE ENOUGH TO AFFECT THE STUDENT'S SCHOOL PROGRAM OR SCHOOL PERFORMANCE.</u> *(Note: this information may be shared with school staff who need to know.)*

MEDICAL HISTORY (CHECK ALL THAT APPLY TO YOUR CHILD)

NB	☐ **ADHD/ADD**	P	☐ **PE Considerations/Limitations**	BD	☐ **Blood Condition**
	Asthma		Description:		Description
RA	☐ Exercise Induced	UH	☐ **Renal: Kidney/Urinary Condition**	NU	☐ **Head Injury/Concussion**
RB	☐ Mild		Description:		Description:
RC	☐ Moderate	GI	☐ **Gastrointestinal Condition**		**Allergies**
RD	☐ Severe		Description:	EC	☐ Environmental
	Diabetes		**Visually Impaired**	ED	☐ Food
EK	☐ Type I	YD	☐ Wears Glasses	EE	☐ Insect
EL	☐ Type II	NP	☐ **Seizure Disorder**	EF	☐ Latex
NH	☐ **Headaches, Migraine**		Date of last seizure:	EG	☐ **Anaphylactic Condition**
	Hearing Impaired		Type of seizure:	EG	☐ **Epi-Pen required**
YB	☐ Hearing Problem		Seizure medications:	EB	☐ Other Allergy:
YB	☐ Hearing Aids				Reacts to:
	Description:	ME	☐ **Muscle or Bone Condition**		Describe allergic reaction:
CG	☐ **Cardiovascular Condition**		Description:		
	Description:				

Is medication needed for any condition? ☐ Y ☐ N

Is medication needed at school? ☐ Y ☐ N

Medication at school (over the counter <u>or</u> prescription) requires Form #157, "Medication at School".

If **<u>YES</u>**, please list name(s) of medication, dose, and schedule: _____

_____

What condition is being treated by this medication? _____

List major operations, injures, or hospitalizations including dates: _____

☐ **I give permission to my child's school nurse to add immunization information into the Washington State Immunization Information System to help the school maintain my child's immunization records.**

	Medical Exam	Eye Exam	Dental Exam
Last Exam Date/Doctor			
Health Insurance Co.			

In an emergency, transport to _____ hospital.

Are there any health-related information or concerns that you can tell us about your child that you feel will help the school staff to better understand and work with them? _____

_____

<u>AUTHORIZATION FOR EMERGENCY PROCEDURE</u>

If the parent(s)/guardian(s) and health care provider named above cannot be reached at the time of an emergency, and if immediate observation or treatment is urgent in the judgement of the school authorities, I authorize and direct the school authorities to send the student to the hospital or doctor most easily accessible. I understand that I will assume full responsibility of the payment of any services rendered.

Date _____ Parent/Guardian Signature _____ _____/_____/_____

Home Phone Cell Phone Work Phone