



Student Health History

Student Name (Last) _____ (First) _____ Birth date: _____

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) EG ☐ Anaphylaxis (Epi-pen prescribed) Allergen/s: EK ☐ Diabetes Type 1 NP ☐ Seizures – (Emergency medication required) RG ☐ Asthma – Severe ☐ Other Life-Threatening Condition: _____ Congenital / Genetic AH ☐ Down Syndrome AJ ☐ Fetal Alcohol Spectrum Disorder ☐ Other, Please list: _____ Blood / Hematology BA ☐ Anemia BB ☐ Hemophilia BC ☐ Sickle Cell Disease Trait OJ ☐ History of Severe Nosebleeds ☐ Other Blood Condition: _____ Cardiac / Heart CC ☐ Heart Birth Defect CD ☐ Heart Murmur ☐ Other Cardiovascular Condition: _____ Allergy, Immune, Endocrine, Metabolic and Nutritional ED ☐ Allergy – Food EE ☐ Allergy – Insect ☐ Allergy – Other List: _____ EL ☐ Diabetes Type 2 ☐ Other Endocrine, Immune, Nutritional or Metabolic: _____ Gastrointestinal, Dental and Oral GA ☐ Celiac GG ☐ Food Intolerance List: _____ GL ☐ Lactose Intolerance GF ☐ Encopresis GO ☐ Chronic Constipation GH ☐ Gastric Reflux GJ ☐ Inflammatory Bowel Disease GK ☐ Irritable Bowel Syndrome ☐ Other Gastrointestinal, Liver, Dental, Oral Condition: _____ Musculoskeletal MC ☐ Juvenile Rheumatoid / Idiopathic Arthritis ☐ Please list: _____ Cancer / Tumor ☐ Please list: _____	Nervous System NB ☐ ADHD / ADD diagnosed by: _____ NC ☐ Autism Spectrum Disorder NE ☐ Cerebral Palsy NF ☐ Developmental Disability NH ☐ Migraines NI ☐ Headaches, Recurring NP ☐ Seizure Disorder ☐ Current ☐ History Type: _____ NU ☐ Traumatic Brain Injury ☐ Other Neurological Condition: _____ Transplant OD ☐ List organ and date: _____ Mental or Behavioral Health PA ☐ Anxiety PC ☐ Depression PH ☐ Sleep Disorder ☐ Other Mental or Behavioral Health Condition: _____ Respiratory / Breathing RG ☐ Asthma – Current RH ☐ Asthma – Ever Diagnosed RA ☐ Asthma – Exercised Induced RE ☐ Reactive Airway Disease ☐ Other Respiratory Condition: _____ Skin SB ☐ Eczema or Contact Dermatitis or Psoriasis ☐ Other Skin Condition: _____ Urinary/Genital ☐ Please list: _____ Ear / Hearing YA ☐ Chronic Ear Infections ☐ Currently ☐ Historically YB ☐ Hearing Impaired ☐ Hearing Aid/s ☐ Cochlear Implant ☐ Other Ear Condition: _____ Eye / Vision YF ☐ Wears glasses / contacts YE ☐ Color Vision Deficit YD ☐ Visually Impaired ☐ Other Eye Condition: _____ Other Health Concerns: ☐ Please list: _____
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OC ☐ NO KNOWN HEALTH CONCERNS

Please initial: _____

PLEASE COMPLETE BOTH SIDES OF FORM



Student Health History

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Student Name _____

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? ☐ No ☐ Yes Please list:

Complete **REQUIRED** paperwork
for medication at school.

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 each calendar year.

Medical Devices

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

Stoma

- OKA ☐ Gastrostomy
OKB ☐ Colostomy
OK ☐ Tracheostomy
D ☐
OKE ☐ Urostomy
OK ☐ 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 doctor 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 for 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: _____

Office Use Only Below

IMMUNIZATION VERIFICATION (Office use only)

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

☐ 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.**

☐ Student added to School Module Roster: Grade: _____

Staff who verified immunizations: _____ Date: _____

PLEASE COMPLETE BOTH SIDES OF FORM