PUYALLUP SCHOOL DISTRICT
A Tradition of Excellence

Health History

Student Name		**Phone**	
Date of Birth		**Grade**	
School		**Teacher**	
Parent/Guardian Name		**Doctor Phone**	
Phone		**Dentist Phone**	

LIFE THREATENING CONDITIONS

Does your child have a life-threatening condition?

❑ **Yes**** Please select from **Health Concerns** below

❑ No

**** If yes, you must schedule a meeting with the School Nurse prior to student starting school.* Washington State Law requires that a medication, treatment, and/or healthcare plan is in place prior to starting school.**

Does your child have a current Emergency Action Plan and/or 504? ❑Yes ❑No

MEDICATION

Does your child take medication?

❑ Yes*

❑ No

*If Yes, name of medication _____

Purpose: _____

Will this medication be needed at school?

❑ Yes*

❑ No

***For medications to be administered at school, Washington State Law and District Policy 3416 requires a written Physician's Order of Medication and parent permission to be completed each school year.**

HEALTH CONCERNS

Have you ever been told by a health care professional that your child has:

❑ **ADD/ADHD** – *(circle one)*

❑ **Allergies** *Type* _____
Medication required **Yes*** ____ No ____ Type _____
Describe reaction _____

❑ **Asthma** Uses inhaler **Yes*** ____ No ____
Exercise induced **Yes*** ____ No ____

❑ **Bowel/Bladder Issues** Type _____

❑ **Diabetes** *Meeting with School Nurse is required*

❑ **Dental Issues** Type _____

❑ **Drug/alcohol treatment** Year _____

❑ **Emotional Concerns** – (circle)
Depression/Anxiety/Eating Disorder/Other _____

_ **Frequent cold sore throats earache**

❑ **Headaches** Frequency _____

❑ **Head injury** Concussion Yes ____ No ____
Date _____ Lost consciousness Yes ____ No ____

❑ **Hearing** Aids Preferential Seating Tubes

❑ **Heart Condition** _____
Restrictions/Limitations _____

❑ **Major Illness/Surgery/Hospitalization Year** _____
Describe _____

❑ **Neurological conditions** _____

❑ **Nose bleeds** *Frequency* _____

❑ **Other bleeding conditions** _____

❑ **P.E. Limitations** _____
For what reason? _____

❑ **Seizure Disorder** *Describe type* _____
Last seizure _____

❑ **Skin Condition** _____

❑ **Speech Difficulty Therapy**

❑ **Stomach Aches cramps tires easily**

❑ **Vision Problem** Contacts Glasses
Reading Distance Both

❑ **Other Concerns**
_____

DEVELOPMENTAL HISTORY

Was there a health problem/handicap at birth?
❑Yes ❑No Please describe: _____
Normal Pregnancy: ❑Yes ❑No Normal Delivery: ❑Yes ❑No
If no, explain: _____
Birth Weight: _____ Talked words (age) _____
Walked (age) _____
Do you feel your child's development has been equal to other children's?
❑Yes ❑No If No, why not? _____
_____

Do you have concerns about your child's hearing, vision, or speech?
❑Yes ❑No Specify _____
Last Medical exam: Date: _____ Provider: _____
Last Eye exam: Date: _____ Provider: _____
Last Dental exam: Date: _____ Provider: _____
Does your child have medical insurance? ❑Yes ❑No
Does your child have dental insurance? ❑Yes ❑No
Is your child covered by Medicaid (Healthy Options, DSHS, "medical coupons") ❑Yes ❑No
Is there any other health related information that school staff should know? _____
_____

Washington State Immunization Law 28A.31.118 requires that a Certificate of Immunization be completed for each child attending school or day care center.

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

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I understand that the information given above will be shared with appropriate school staff to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of medical emergency, I authorize and direct school staff to send my child to the most accessible hospital or physician. I understand that I will assume full responsibility for payment of any transport or emergency medical services rendered.

_____

Parent/Guardian Signature Date