Student Health History
School Year 2024-25

Student last name: ____________________

First name: ____________________

__________ Birthdate __________ Grade __________ School

Please check all conditions that apply. If your child has no chronic health conditions, skip to the final box and sign below. All information given on this form will be shared with appropriate school staff on a "need to know" basis in order to provide for the health and safety of your student.

LIFE-THREATENING HEALTH CONDITIONS | Required Health Room Forms: www.lkstevens.wednet.edu/health-forms

RG	SEVERE Asthma (see below if not severe)	
EG	SEVERE Allergy (requiring Epipen) Allergy to: ____________	
EK	Diabetes Type 1 (insulin dependent)	
GE	Dysphagia: ____________	
NP	Seizures	C_ Heart condition: ____________
NW	Seizure - Ever Diagnosed	BB Hemophilia

State Law requires that students with life threatening conditions such as anaphylaxis, asthma, seizure, cardiac, hemophilia or diabetes have a parent meeting with the School Nurse & care plan completed prior to the first day of school.

In order for your student to attend school, please contact the building nurse **after** all paperwork is complete.

Other Conditions

NB	ADHD/ADD diagnosed by: ____________
ED	Allergy - Food: ____________
EE	Allergy - Insect: ____________
EM	Allergy - Medication: ____________
EC	Allergy - Seasonal: ____________
EV	Allergy - Animal: ____________
EB	Allergy - Other: ____________
PA	Anxiety
RG	Asthma currently treated (not severe) using inhaler
RH	Asthma past history no longer using inhaler
NC	Autism Spectrum Disorder
B_	Blood condition: ____________
GA	Celiac Disease
NE	Cerebral Palsy
YA	Chronic Ear Infections
UB	Chronic Urinary Tract Infections
NU	Concussion history/Traumatic Brain Injury
EJ	Cystic Fibrosis
PC	Depression
NF	Developmental Disability
EL	Diabetes Type 2
EN	Eating Disorder
GH	GERD/Acid Reflux
N_	Headaches OR Migraines
GK	Irritable Bowel OR Crohns
M_	Musculoskeletal Disorder: ____________
RE	Reactive Airway Disease
EU	Thyroid condition: ____________

Other pertinent medical history (hospitalizations, injuries, other diagnoses/conditions not listed):

List ALL current medications (circle those that will be taken at school):

Please note: State law requires written permission from a health care provider and parent/guardian before any medications (prescription AND over the counter) can be carried and/or taken at school. Forms are available online and in each school office.

My student wears: Glasses (YF) Contact Lenses (YF) Hearing Aids (YB) Other:

My student has **NO CHRONIC HEALTH CONDITIONS** at this time.

If parent/guardian or authorized emergency contact 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 school authorities to send the student to the nearest and most appropriate healthcare facility. I understand that I will assume full responsibility for the payment of any services rendered.

__________ **Date** __________ **Signature** __________ **Relationship** __________ **Phone**