



## SCHOOL STUDENT HEALTH INFORMATION ANNUAL UPDATE

We use this updated information to assist in caring for your student at school. Please *carefully* complete **BOTH SIDES** of this form and return to the school Health Office as soon as possible.

In order to provide a safe and healthy environment for your child, this confidential information will be accessible to: School Health Personnel, your child's teachers and care givers, and emergency medical personnel.

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: M ☐ F ☐

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**PARENTS/GUARDIANS:** If your child has a serious medical condition, it is vital that you discuss this with your Health Office immediately. **We MUST be alerted to LIFE THREATENING HEALTH CONDITIONS prior to the start of school.**

These conditions may require an Emergency Care Plan with Emergency Medications (per RCW28A.210.320). **If an emergency medication or plan is needed, and the proper paperwork is not in place, we are required to EXCLUDE the child from school.** By completing and signing this form, you as the parent/guardian agree that you will be responsible for communicating ANY changes to this form with the school office and health office.

**LIFE THREATENING HEALTH CONDITIONS:** If you check any of these boxes, you must contact the School Health Room.

- **Asthma \* Severe \*** - please answer the following questions

**Yes** ☐ **No** ☐ Does this child use rescue inhaler routinely for asthma symptoms?  
Daily ☐ Weekly ☐ Monthly ☐ (ie: Atrovent, ProAir, Ventolin)

**Yes** ☐ **No** ☐ Has your child used steroids for asthma symptoms in the past year?  
☐ inhaled steroids (ie: Flovent or Qvar) or ☐ Prednisone

**Yes** ☐ **No** ☐ Has your child been hospitalized for asthma in the past year?

- **Allergy/Anaphylaxis - SEVERE, WITH AN EPINEPHRINE PRESCRIPTION (EPI-PEN)**

Cause of allergy (Bee sting, Peanut/Nut, Food, Medication, Other): \_\_\_\_\_

Describe previous reaction: \_\_\_\_\_

- **Diabetes, Type 1**

Date of Diagnosis: \_\_\_\_\_ ☐ Uses a pump ☐ If so, for how many years in use? \_\_\_\_\_

- **Seizure Disorder**

☐ Is currently taking seizure medication

- **Other potentially life threatening issues:** \_\_\_\_\_

- **My child has no potentially life threatening health conditions.**

- Allergy, **not** life threatening:

Allergen: \_\_\_\_\_ Reaction: \_\_\_\_\_

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- History of Concussion / Head Injury:

Date of Injury: \_\_\_\_\_ Was a Health Care Provider Seen? \_\_\_\_\_

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- Hearing Concerns? ☐ Has a known hearing loss ☐ Wears hearing aids?

- Vision Concerns? ☐ Glasses ☐ Contacts

- Other Concerns (Please contact the school health office): \_\_\_\_\_

- **My child has none of the conditions listed above.**

Student Name: \_\_\_\_\_

HEALTH HISTORY: Please check the health conditions that apply to your child.

**Please provide documentation of your child's condition from your medical provider.**

| Health Condition:  | Yes | No | Explain: |
|--|-----|----|----------|
| Brain or Spinal Disorder   |     |    |          |
| Cerebral Palsy   |     |    |          |
| Migraine Headaches   |     |    |          |
| ADD/ADHD / Hyperactivity   |     |    |          |
| Mental Health Behavioral Issues, or depression, anxiety              |     |    |          |
| Heart / Cardiovascular Disease                                       |     |    |          |
| Blood / bleeding disorder  |     |    |          |
| <b>Breathing Issues</b><br>(including <b>Asthma</b> – Mild-Moderate) |     |    |          |
| Digestive / Stomach Issues   |     |    |          |
| Bowel or Bladder Issues  |     |    |          |
| Bladder Issues   |     |    |          |
| Cancer   |     |    |          |
| Other:   |     |    |          |

**Washington School Immunization law RCW 28A.210.120** requires that you must provide medically verified immunization records that are complete or conditional before starting school. **By signing this form, you are giving permission to add your student's immunizations into the Washington State Immunization Information System to maintain your student's immunization records.**

**MEDICATIONS:**

Does your child take medication at home? ☐ Yes ☐ No

Please list here:

**Does your child need to take medication AT SCHOOL?** ☐ YES ☐ NO

**\*\* IF YES YOU MUST CONTACT THE SCHOOL HEALTH PERSONNEL and complete necessary paperwork.** IF medications are needed during the school day; RCW 28A.210.206 requires a written authorization form for medication to be administered at school, **to be signed by the parent/guardian AND a health care provider.**

Ask your school for these forms, or download them from the district website.

**\*includes over the counter, prescription, herbal, and naturopathic medications.\*\***

Doctor's Name: \_\_\_\_\_

**PARENT/GUARDIAN PRINTED NAME:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_