EMERGENCY INFORMATION

In order to provide immediate and safe care for your child and carry out your wishes in case of injury or illness at school, we require the following information. Please fill out completely and please print.

☐ **Please check box if any information in this section is new.**

Student last name: _____

Student name: _____ DOB: _____ Grad year: _____
Last First Middle Initial

Home address: _____ Primary phone: _____
Street City Zip

Lives with: ☐ Parents ☐ Mother only ☐ Mother/stepfather ☐ Guardian ☐ Father only ☐ Father/stepmother

Other: _____

Parent/guardian name 1: _____ E-mail address: _____

Employer: _____ Work phone: _____ Cell phone: _____

Parent/guardian name 2: _____ E-mail address: _____

Employer: _____ Work phone: _____ Cell phone: _____

Primary language spoken at home: ☐ English ☐ Spanish ☐ Other: _____

Day care provider (if applicable): _____ Phone: _____

Please complete the following if student has a non-custodial parent who can make emergency decisions for the student and receive copies of records involving this student, including newsletters, grade reports, correspondence, etc.

☐ **Please check box if any information in this section is new.**

Home address: _____ Primary phone: _____
Street City Zip

Parent/guardian name 1: _____ E-mail address: _____

Employer: _____ Work phone: _____ Cell phone: _____

Parent/guardian name 2: _____ E-mail address: _____

Employer: _____ Work phone: _____ Cell phone: _____

In addition to the parent/guardian, if you cannot be reached, the school may call and release your child to any of the following:

☐ **Please check box if any information in this section is new.**

Name 1: _____ Relationship: _____

Phone: _____ Work phone: _____ Cell phone: _____

Name 2: _____ Relationship: _____

Phone: _____ Work phone: _____ Cell phone: _____

Name 3: _____ Relationship: _____

Phone: _____ Work phone: _____ Cell phone: _____

Please list all children in Snohomish School District this year. (Please list students in this school first.)

☐ **Please check box if any information in this section is new.**

Last Name	First Name	School	Grade

Signature of parent/guardian _____ Date: _____

******THIS FORM MUST BE RETURNED AT REGISTRATION***

TO BE COMPLETED BY PARENT/GUARDIAN

HEALTH HISTORY

3418F2

(Last, First): _____ DOB:_____ ☐ M ☐ F Grade:_____ ID #:_____

Student Name

This information is needed to plan an appropriate program for your student and to prepare for any emergency situation if one should arise. ***Washington state law requires that LIFE-THREATENING CONDITIONS such as ANAPHYLAXIS, DIABETES, SEIZURES or ASTHMA have a health plan completed prior to the first day of school. Please contact the building nurse as soon as possible to ensure all paper work is complete.**

Congenital /Genetic Conditions

AG ☐ Other _____
AJ ☐ Fetal Alcohol Spectrum Disorder _____

Hematology (Blood)

BB ☐ ***Hemophilia** _____
BC ☐ Sickle Cell Anemia _____
BD ☐ Other Blood Condition _____

Cardiovascular/Heart Conditions

CG ☐ Other _____

Endocrine, Allergy, Immune System, Metabolic, and Nutritional

EB ☐ Other Allergy _____
ED ☐ Allergy-Food _____
EE ☐ Allergy–Insect _____
EG ☐ ***Anaphylactic Condition (EpiPen)** _____
EJ ☐ Cystic Fibrosis _____
EK/L ☐ ***Diabetes Type 1** ☐ ***Diabetes Type 2**
EM ☐ Allergy to Medication(s) _____
EN ☐ Eating Disorder _____
EO ☐ Other Endocrine, Immune, or Metabolic Disorder _____
EU ☐ Thyroid Disorder _____

Gastrointestinal, Dental, and Oral Conditions

GA/J/K ☐ Celiac Disease ☐ Crohn's ☐ Irritable Bowel
GD ☐ Dental Condition _____
GG ☐ Food Intolerance _____
GH/L ☐ Gastroesophageal Reflux ☐ Lactose Intolerance
GI ☐ Other _____
GM ☐ Liver Disease _____
GN ☐ Oral Condition _____

Musculoskeletal and Connective Tissue

MB ☐ Other _____
MC ☐ Juvenile Rheumatoid Arthritis _____
MD ☐ Muscular Dystrophy _____
MF ☐ Osgood-Schlatter _____
MH ☐ Scoliosis _____

Skin and Subcutaneous Tissue

SB ☐ Contact Dermatitis (Eczema) _____
SH ☐ Other _____

Nervous System

☐ ADHD-Inattentive ☐ ADHD-Hyperactive/Impulsive
NB ☐ ADHD-Combined, Diagnosed by: _____
NC ☐ Autism Spectrum Disorder _____
ND ☐ Central Nervous System Conditon Other _____
NE ☐ Cerebral Palsy _____
NF ☐ Developmental Disability _____
NH/I/J ☐ Migraines ☐ Headaches ☐ Shunt
NN ☐ Paralysis _____
NP ☐ ***Seizure Disorder** _____
NQ ☐ Sensory Condition _____
NS ☐ Spina Bifida _____
NT ☐ Spinal Cord Injury _____
NU ☐ Traumatic Brain Injury _____

Behavioral Health Conditions

PA ☐ Anxiety _____
PC ☐ Depression _____
PH ☐ Sleep Disorder _____
PI ☐ Tourette Syndrome _____
PJ ☐ Other _____

Respiratory

RA ☐ Exercise-Induced Bronchospasm ☐ ***Inhaler**
RE ☐ Reactive Airway Disease _____
RF ☐ Other _____
RG ☐ ***Asthma – current** ☐ ***Inhaler**
RH ☐ Asthma – ever-diagnosed

Neoplasms (Cancer/Tumors)

TI ☐ Other _____

Renal and Genitourinary

UB ☐ Chronic Urinary Tract Infection _____
UC ☐ Dysmenorrhea (painful menstrual periods) _____
UD ☐ Genito-Urinary Condition Other _____
UH ☐ Renal Condition Other _____

Eye and Ear

YB ☐ Hearing Impaired _____
YA/YC ☐ Chronic Ear Infections _____ ☐ Ear Condition _____
YD ☐ Visually Impaired _____
YE ☐ Eye Condition _____
YF ☐ Wears Glasses _____ Last Eye Eval: _____

Is medication needed at home? ☐ No ☐ Yes Please list: _____
Is medication needed at school? ☐ No ☐ Yes Please list: _____
Hospital preference: _____

Medical History (check all that apply) or ☐ No health condition at this time (please sign below).

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 judgment of school authorities. I authorize and direct the school authorities to send the student to the hospital or doctor most accessible. I understand that I will assume full responsibility for the payment of any services rendered. I understand that the information given above will be shared with appropriate school staff that needs to know in order to provide for the health and safety of my student. I give my consent for Snohomish School District staff to obtain and enter vaccine dates and information into the WAIIS to maintain my student's immunization record.

Date:_____ **Parent/Guardian Signature:** _____ Phone:_____