Orting School District
Connect - Inspire - Empower

Health Services – Student Health History Form

Student Name (Last): _____ **First:** _____ **Date of Birth**: _____ **Grade**: _____

State law requires that students with life-threatening conditions such as anaphylaxis, severe asthma, diabetes, or seizures have medical orders updated annually and a care plan in place prior to the first day of school. Parents/Guardians are responsible for notifying the school of any changes in their student's health status.

Does this student have a life-threatening health condition? ☐ **Yes*** ☐ **No** ***If you have checked yes, please provide the school with medical orders from their medical provider.**

Medical History (Check all that Apply)

☐ **Life-Threatening Conditions**
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

☐ **Blood / Hematology**
BA ☐ Anemia
BB ☐ Hemophilia
BC ☐ Sickle Cell Disease Trait
OJ ☐ History of Severe Nosebleeds
BA ☐ Other Blood Condition: _____

☐ **Cardiac / Heart**
CC ☐ Heart Birth Defect
CD ☐ Heart Murmur
☐ Other Cardiovascular Condition: _____

☐ **Allergy, Immune, Endocrine, Metabolic, and Nutritional**
ED ☐ Allergy - Food
EL ☐ Allergy- Insect
☐ Allergy - Other: _____
EL ☐ Diabetes Type 2
☐ Other Condition: _____

☐ **Gastrointestinal, Dental, and Oral**
GA ☐ Celiac
GG ☐ Food Intolerance: _____
GL ☐ Lactose Intolerance: _____
GF ☐ Encopresis
GO ☐ Chronic Constipation
GH ☐ Gastric Reflux
GJ ☐ Inflammatory Bowel Disease
GK ☐ Irritable Bowel Syndrome
☐ Other Gastro/Dental/Oral Condition: _____

☐ **Musculoskeletal**
MC ☐ Juvenile Rheumatoid / Idiopathic Arthritis
☐ Other: _____

☐ **Cancer / Tumor**
☐ Please list: _____

☐ **Nervous System**
NB ☐ ADHD / ADD
NC ☐ Autism Spectrum Disorder
NE ☐ Cerebral Palsy
NF ☐ Developmental Disability
NH ☐ Migraines
NI ☐ Headaches, recurring
NP ☐ Seizure Disorder: ☐ Current ☐ History
NU ☐ Traumatic Brain Injury
☐ Other Neurological Condition: _____

☐ **Transplant**
OD ☐ List Organ: _____

☐ **Mental or Behavioral Health**
PA ☐ Anxiety
PC ☐ Depression
PH ☐ Sleep Disorder
☐ Other Mental/Behavioral Condition: _____

☐ **Respiratory / Breathing**
RG ☐ Asthma - Current
RH ☐ Asthma: ☐ Mild ☐ Moderate ☐ Severe
RA ☐ Asthma – Exercise Induced
RE ☐ Reactive Airway Disease
☐ Other Respiratory Condition: _____

☐ **Skin**
SB ☐ Eczema, Contact Dermatitis or Psoriasis
☐ Other Skin Condition: _____

☐ **Renal / Kidney**
☐ List: _____

☐ **Ear / Hearing**
YA ☐ Chronic Ear Infections: ☐ Current ☐ History
YB ☐ Hearing Impairment, Hearing Aid/s, Cochlear Implant/s
☐ Other Ear Condition: _____

☐ **Eye / Vision**
YF ☐ Wears glasses / contacts
YE ☐ Color Vision Deficit
YD ☐ Visually Impaired
☐ Other Eye Condition: _____

☐ **Student has no known health concerns. Please initial: _____**

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Medications

Is medication needed at home? ☐No ☐Yes Please list: _____
Is Medication needed at school? ☐No ☐Yes Please list: _____ **It is required you have medical orders and paperwork on file annually for medications needed a 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 annually.

Medical Devices

☐**Medical Devices** OLA ☐ Vagal Never Stimulator OLB ☐ Automatic Internal Cardiac Defibrillator OLC ☐ Pacemaker OLD ☐ Gastrostomy tube OLE ☐ Jejunostomy tube ☐ Prosthesis List: _____ ☐ Brace ☐ Other Medical Device(s): _____	☐**Stoma** OKA ☐ Gastrostomy OKB ☐ Colostomy OKD ☐ Tracheostomy OKE ☐ Urostomy ☐ Other: _____ ☐**Physical Activity / Mobility** ☐ Wheelchair ☐ Crutches ☐ Walker ☐ Other: _____

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 judgment 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: _____

IMMUNIZATION VERIFICATION – TO BE COMPLETED BY SCHOOL STAFF

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

WAIIS CIS Immunizations Status is ☐ COMPLETE OR ☐ CONDITIONAL and conditional status expiration date is after the first day of school
☐Parent/Guardian has signed the conditional status acknowledgement on CIS.
OR
☐Student is not in WAISS. Medically verified immunization recorded 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 WAIIS CIS or in WAIIS
☐COE is fully complete ☐Permission to enter statement signed **OR**
☐Immunization State is NOT COMPLETE on the WAIIS CIS. **Student may not start school until documentation of missing immunizations is received that will change the CIS status to COMPLETE or CONDITIONAL (unless they are classified as McKenney Vento or Foster Care)**

☐Student added to School Module Roster Grade: _____ Immunization Verified by:_____ Date:_____