



6972 Keene Road, West Richland, WA 99353

Student Health History Form

Parent/guardian, please complete: Name of Student: _____
School: _____ Grade: _____ Date of Birth: _____ Sex: Male Female

Life Threatening Medical Conditions:

WA State law requires a medication/treatment order from a Health Care Provider if your child's health condition will *put your child in danger of death during the school day*. Written orders must be received by the School Nurse, and if appropriate, a care plan must be in place **before your child can attend school**.

Does your child have a LIFE THREATENING HEALTH CONDITION? No Yes
If yes, please state condition: _____

No Yes **Severe Allergic reaction to Bee Sting. Anaphylactic** No Yes Describe: _____
 No Yes **Severe Allergic reaction to Food or Nuts. Type:** _____ **Anaphylactic** No Yes
Describe _____

No Yes **Mild Allergic reaction to Food or Nuts. Type:** _____ **Reaction:** _____

No Yes **Other Allergic Reactions. Type:** _____ **Reaction:** _____

No Yes **Asthma. Will your child require asthma medication during school hours?** No Yes

No Yes **Diabetes. Type:** _____ **Self manage:** _____ **Pump:** No Yes

No Yes **Heart Condition. Diagnosis:** _____ **Pacemaker:** No Yes

No Yes **Bleeding Disorder. Diagnosis:** _____

No Yes **Orthopedic Condition. Diagnosis:** _____

No Yes **Seizure/Neurological Disorder. Describe:** _____

No Yes **GI/Feeding condition. Describe:** _____

No Yes **Bowel/Bladder condition. Describe:** _____

No Yes **Other Health Concerns:** _____

No Yes **Does your child have any other condition that would affect classroom performance or P.E. activities?**

If yes, please explain: _____

No Yes **Behavioral/Emotional Concerns:** _____

No Yes **Glasses:** _____ **Contacts:** _____ **Reason:** _____ **Date of last eye exam:** _____

No Yes **Hearing Impairment:** _____ **Date of last hearing exam:** _____ **Hearing Aids:** No Yes

No Yes **Health Insurance: Name** _____

No Yes **Primary Care Provider (Doctor/ARNP/PA)** _____

Daily Medications:

State law requires *written authorization from a Health Care Provider and parent* before **any** medication, prescription or over-the-counter, can be given at school. Medication forms are available online at www.rsd.edu.

No Yes **Medication needed at school:** (specify): _____ (Authorization needed)

No Yes **Medication needed at home:** (specify): _____

Parent/Guardian (Printed Name): _____

Parent/guardian signature: _____ **Date** _____

Telephone: (Home) _____ (Cell) _____ (Work) _____

This information is considered confidential. To ensure the health and safety of your child, it will be shared with school staff as needed during the time your child is enrolled in Richland School District, unless you request otherwise in writing.