



Student Health History

School Year 2026-27

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.

Student last name: _____

First name: _____

Birthdate _____ Grade _____ School _____

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 _____