

PUYALLUP SCHOOL DISTRICT

HEALTH HISTORY

NAME:	DOB:	GRADE:	DATE:
PARENT/GUARDIAN:		RELATIONSHIP TO STUDENT:	

LIFE THREATENING CONDITIONS

Does your child have a life threatening health condition?
Yes** _____ Please select from **Health Concerns** below
 No _____
****If yes, you must schedule a meeting with the School Nurse prior to student starting school. Washington State Law requires that a medication, treatment, and/or healthcare plan is in place prior to starting school.**
 Does your child have a current Emergency Action Plan and/or 504? _____

MEDICATION

Does your child take any medication? Yes _____ No _____
 If Yes, name of medication _____
 Purpose: _____
 Will the medication be needed at school? **Yes*** _____ No _____
***For medications to be administered at school, Washington State Law and District policy #3416 requires a written Physician's Order for Medication and parent permission to be completed each school year.**

HEALTH CONCERNS

Have you ever been told by a health care professional that your child has:
 _____ **ADD/ADHD** (circle one)
 _____ **Allergies** Type _____
 Medication required **Yes*** _____ No _____ Type _____
 Describe reaction _____
 _____ **Asthma** Uses inhaler **Yes*** _____ No _____
 Exercise induced Yes _____ No _____
 _____ **Bowel/Bladder Issues** Type _____
 _____ **Diabetes** *Meeting with the School Nurse is required*
 _____ **Dental Issues** Type _____
 _____ **Drug/alcohol treatment** Year _____
 _____ **Emotional Concerns** (circle)
 Depression/ Anxiety/Eating Disorder/Other _____
 _____ **Frequent cold/sore throats/earache** (circle)
 _____ **Headaches** Frequency _____
 _____ **Head injury** Concussion Yes _____ No _____
 Date _____ Lost consciousness Yes _____ No _____
 _____ **Hearing** (circle) Aids _____ Preferential Seating _____ Tubes _____
 _____ **Heart Condition** _____
 Restrictions/Limitations _____
 _____ **Major Illness/Surgery/Hospitalization** Year _____
 Describe _____
 _____ **Neurological conditions** _____
 _____ **Nose bleeds** Frequency _____
 _____ **Other bleeding conditions** _____
 _____ **P.E .Limitations** _____
 For what reason? _____
 _____ **Seizure Disorder** Describe type _____
 Last seizure _____
 _____ **Skin Condition** _____
 _____ **Speech Difficulty/Therapy** (circle)
 _____ **Stomach aches/cramps/tires easily** (circle)
 _____ **Vision Problem** Contacts _____ Glasses _____
 Reading _____ Distance _____ Both _____
 _____ **Other Concerns** _____

DEVELOPMENTAL HISTORY

Was there a health problem/handicap at birth?
 Yes/No Please describe: _____
 Normal Pregnancy: Yes/No Normal Delivery: Yes/No
 If no, explain: _____
 Birth Weight: _____ Talked words (age) _____
 Walked (age) _____
 Do you feel your child's development has been equal to other children's? Yes/No If No, why not?

 Do you have concerns about your child's hearing, vision, or speech? Yes ___ No ___ Specify _____
 Last medical exam: Date: _____ Provider: _____
 Last eye exam: Date: _____ Provider: _____
 Last Dental exam: Date: _____ Provider: _____
 Does your child have medical insurance? Yes _____ No _____
 Does your child have dental insurance? Yes _____ No _____
 Is your child covered by Medicaid? (Healthy Options, DSHS, "medical coupons") Yes _____ No _____
 Is there any other health related information that school staff should know?

Washington State Immunization Law 28A.31.118 requires that a Certificate of Immunization be completed for each child attending school or day care center.

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I understand that the information given above will be shared with appropriate school staff to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of medical emergency, I authorize and direct school staff to send my child to the most accessible hospital or physician. I understand that I will assume full responsibility for payment of any transport or emergency medical services rendered.

Parent/Guardian Signature _____

Date _____