

## STUDENT HEALTH HISTORY

**Student:** \_\_\_\_\_ M/F Birth Date: \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_  
                    Last Name                      First Name                      Middle

Parent/Guardian(s) \_\_\_\_\_ Phone: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_

### **PART I: SERIOUS HEALTH CONDITIONS:**

Student is being treated by a Licensed Health Care Provider. For the following conditions, **Parent/guardian is required by Washington State Law (WAC 180-38-045) to meet with the school nurse before your student will be allowed to start school.** These conditions are potentially life threatening. Please mark and explain all that apply to your child.

\_\_\_\_\_ **Diabetes:** \_\_\_\_\_  
\_\_\_\_\_ **Seizure Disorder:** \_\_\_\_\_  
\_\_\_\_\_ **Heart Condition (serious):** \_\_\_\_\_  
\_\_\_\_\_ **Allergy, Life Threatening (requires EpiPen):** \_\_\_\_\_  
\_\_\_\_\_ **Swallowing or eating problems:** \_\_\_\_\_  
\_\_\_\_\_ **Other Serious Medical Condition:** \_\_\_\_\_

### **PART II: ASTHMA (may require to meet or conference with School Nurse prior to attending school yearly).**

\_\_\_\_\_ **Asthma, severe** (takes daily medication/inhaler; has a daily or constant symptom or frequent 'flare-ups' which limit daily activity): \_\_\_\_\_  
\_\_\_\_\_ **Asthma, moderate** (takes daily medication/inhaler; has symptoms or flare-ups several times per month): \_\_\_\_\_  
\_\_\_\_\_ **Asthma, mild** (no daily medication/inhaler; has symptoms or flare-ups no more than 1-2 times per month) \_\_\_\_\_

### **PART III: OTHER HEALTH CONDITIONS**

\_\_\_\_\_ **Allergies** (not requiring EpiPen): \_\_\_\_\_  
\_\_\_\_\_ **Social/emotional/behavioral or mental health problems** (ADHD, anxiety, mood problems etc) \_\_\_\_\_  
\_\_\_\_\_ **Other:** \_\_\_\_\_  
\_\_\_\_\_

### **PART IV: MEDICATIONS**

Please list medications (including inhalers) which need to be taken at school: \_\_\_\_\_  
Please list any medications taken at home \_\_\_\_\_

**Authorization from the health provider and parent is required for ALL MEDICATION at school** (form available from school nurse and hsd401.org/)

**Parent/guardian signature** \_\_\_\_\_ **Date** \_\_\_\_\_

