KENT SCHOOL DISTRICT
Kent, Washington

To be completed by parent/guardian

HEALTH HISTORY

School _____
Grade _____
Teacher _____

Today's Date_____
Name of Student_____ Birthdate _____ Sex:☐M ☐F

This information is needed to plan an appropriate program for your student and to prepare for any emergency situation if one should arise. Your school nurse will contact you if there are any additional questions.

DOES THE STUDENT HAVE:

MEDICAL HISTORY (check all that apply)			**Please explain any yes answers.**
Allergies (specify)	No ☐	Yes ☐	
Life threatening allergy (anaphylaxis)*	No ☐	Yes ☐	(*If yes, complete reverse side)
Bee/insect allergy	No ☐	Yes ☐	
Asthma *	No ☐	Yes ☐	(*If yes, complete reverse side)
Concerns/defect present at birth	No ☐	Yes ☐	
Frequent ear infections	No ☐	Yes ☐	
Hearing loss	No ☐	Yes ☐	
Speech difficulties	No ☐	Yes ☐	
Severe headaches	No ☐	Yes ☐	
Seizures	No ☐	Yes ☐	
Neurological condition	No ☐	Yes ☐	
ADD/ADHD (circle one, diagnosed by whom)	No ☐	Yes ☐	
Heart condition	No ☐	Yes ☐	
Diabetes *	No ☐	Yes ☐	(*If yes, see reverse side)
Blood disorder	No ☐	Yes ☐	
Orthopedic condition	No ☐	Yes ☐	
Chronic condition/disability	No ☐	Yes ☐	
Vision concerns	No ☐	Yes ☐	Wears: Glasses _____ Contacts _____ Other _____
Serious injury/surgery	No ☐	Yes ☐	_____ Date: _____
Emotional health concerns	No ☐	Yes ☐	
Other health concerns	No ☐	Yes ☐	

MEDICATION

Is medication needed at home?	No ☐	Yes ☐	_____ Name of medication
Is medication needed at school?**	No ☐	Yes ☐	_____ Name of medication

****State law requires written permission from a licensed health care provider and parent before any medication, prescription or over-the-counter, may be taken at school. A form is available from the school office.**

Is there anything you want to tell us about your student which you feel will help school staff to better understand and work with him/her?

_____

I understand that the information given above will be shared with appropriate school staff who need to know in order to provide for the heath and safety of my student. If parents/guardian or authorized emergency contact 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.

Signature _____ Relationship _____ Phone _____

- *Please turn over for more information* -

Anaphylaxis

If your student has an anaphylactic allergy as indicated on the reverse side of this form, please answer the following questions:

1. What is your student allergic to?_____
2. What are your student's symptoms?_____
3. Has your student been prescribed an Epi-pen? ☐ Yes ☐ No

Please contact the school nurse to help implement your student's individualized healthcare plan.

Diabetes

There is a state law, which requires all students with diabetes to have an individualized health care plan implemented in the school setting. If your student is diabetic, please contact the school nurse to help write your student's plan.

Asthma

If your student has asthma as indicated on the reverse side of this form, please answer the following questions:

1. How long has your child had asthma? _____ years _____ months
2. How many days would you estimate he/she missed school last year due to asthma? _____
3. How many times in the past year has your child been:
   a) Hospitalized overnight or longer for asthma? (check one) ☐ none ☐ one ☐ two-four ☐ more than four
   b) Treated in an emergency room? (check one) ☐ none ☐ one ☐ two-four ☐ more than four
   c) Treated in a Doctor's office for non-routine asthma? (check one) ☐ none ☐ one ☐ two-four ☐ more than four
4. What are your child's early warning signs of an asthma episode? (check all that apply)
   ☐ cough ☐ cold symptoms ☐ drop in peak flow
   ☐ wheezing ☐ decreased exercise ☐ other_____
5. If your child's asthma is monitored with a peak flow meter, write in his/her best peak flow rate. _____
6. Does your child have and use a nebulizer machine at home? ☐ yes ☐ no
7. If your child takes medication for their asthma at home please provide the name of any medications:

_____ _____ _____

Life Threatening Conditions

RCW 28A.210.320-Children with Life-Threatening Conditions, requires a medication or treatment order as a prerequisite for children with life-threatening conditions to attend public schools. The new law defines "life-threatening condition" as a health condition that will put the child in danger of death during the school day, if a medication or treatment order and a nursing care plan are not in place. Potential life-threatening conditions include, but are not limited to, students with seizure disorders, diabetes, life-threatening allergies, and some students with asthma and heart conditions. If this law applies to your student, please contact the nurse at your child's school.

Signed: _____ Date: _____