

Student Health History--Confidential Information

Auburn School District No. 408 • Auburn, Washington

Name _____ School West Auburn High School Grade _____ Sex _____

Date of birth _____ Allergies _____

If yes, state reaction _____

Has your child ever received medical treatment by a specialist? Yes No Date of treatment _____

Reason for treatment _____

Primary-care Provider _____ Phone number (_____) _____

Medical History--Please complete the following by marking yes or no in each area. If you check "yes," complete the comment line.

Comment

Has your child ever:

Had a head injury? Yes No _____

Lost consciousness Yes No _____

Had a seizure? (F) ... Yes No _____

Has your child had:

A serious illness? Yes No _____

A serious injury/accident? Yes No _____

Surgery/hospitalization Yes No _____

Does your child have a history of:

B..... Allergies? Yes No _____

A..... Asthma? (buff) ... Yes No _____

B10.... Bee-sting allergy?..... (pink) ... Yes No _____

D10.... Diabetes Yes No _____

H..... Hearing problem? Yes No _____

C..... Heart/blood condition? Yes No _____

J..... Skeletal/muscular problem? Yes No _____

K..... Bowel/bladder problems? Yes No _____

E..... Vision problems? Yes No _____

S..... Skin conditions? Yes No _____

L..... Attention Deficit Disorder? Yes No _____

L..... Emotional/behavioral problems? Yes No _____

M..... Need for medical equipment? Yes No _____

A chronic condition or other problem?..... Yes No _____

Is there a condition that significantly limits PE?..... Yes No _____

Is there any other health concern or special need?..... Yes No _____

Medication:

Name of Medication

Is medication needed at home? Yes No _____

Is medication needed at school? (form) ... Yes No _____

Sate law requires written doctor and parent permission for taking any medication at school. Please obtain a form in the school office.

Thank you for completing this form. Healthy students make better learners.

In understand the information I have given may be shared with those school staff members who need to know in order to monitor my child's condition and provide an environment for optimal educational planning and learning.

Signature of parent/guardian

Date