Student Health History ☐ New Enrollment ☐ Annual Review

Student Name (Last,First)________________________Birthdate:_______________Grade:________ Gender:_______

1. Does your student have a LIFE-THREATENING health condition? ☐ Yes ☐ No

Life-Threatening Conditions: (Care plan is REQUIRED)
- EG ☐ **Anaphylaxis (Epi-pen prescribed)**
  - ☐ Allergic to__________________________
  - ☐ Date of last reaction ______________________________
- EK ☐ **Diabetes Type 1**
- NP ☐ **Seizures – Emergency medication required?**
  - Type: ______________________________
  - Date of last seizure ____________________
- RD ☐ **Asthma – Severe**
- OB ☐ **Other Life-Threatening Condition:**
  - ____

If yes, state law requires that students with life-threatening conditions such as anaphylaxis, severe asthma, diabetes, or seizures have a completed care plan along with any required medication prior to the first day of school. Fill out the life-threatening conditions section left AND contact the school nurse as soon as possible for additional forms.

2. Does your student have any known health concerns? ☐ Yes ☐ No Please initial: ________

MEDICAL HISTORY (check all that apply)

Congenital/Genetic
- AH ☐ Down Syndrome
- AJ ☐ Fetal Alcohol Spectrum Disorder
- AG ☐ Other conditions, please describe:
  - ____

Blood / Hematology
- BA ☐ Anemia
- BB ☐ Hemophilia
- BC ☐ Sickle Cell Disease Trait
- OJ ☐ History of Severe Nosebleeds
- BD ☐ Other Blood Condition:
  - ____

Cardiac / Heart
- CC ☐ Heart Birth Defect
- CD ☐ Heart Murmur
- CG ☐ Other Cardiovascular Condition:
  - ____

Allergy, Immune, Endocrine, Metabolic and Nutritional
- ED ☐ Allergy – Food: ____________________________
- EE ☐ Allergy – Insect: ___________________________
- EB ☐ Allergy – Other List: _________________________
- EL ☐ Diabetes Type 2
- EO ☐ Other Endocrine, Immune, Nutritional or Metabolic: EQ/ER
  - ____

Gastrointestinal, Dental and Oral
- GA ☐ Celiac
- GG ☐ Food Intolerance / Religious Preference
  - List: ________________________________
- GL ☐ Lactose Intolerance
- GF ☐ Encopresis
- GO ☐ Chronic Constipation
- GH ☐ Gastric Reflux
- GJ ☐ Inflammatory Bowel Disease
- GK ☐ Irritable Bowel Syndrome
- GI/GN ☐ Other Gastrointestinal, Liver, Dental, Oral Condition:
  - ____

Musculoskeletal
- MC ☐ Juvenile Rheumatoid / Idiopathic Arthritis
- ME ☐ Please list:
  - ____

Cancer / Tumor
- DA ☐ Please list:
  - ____

Nervous System
- NB ☐ ADHD / ADD diagnosed by: ______________________
- NC ☐ Autism Spectrum Disorder
- NE ☐ Cerebral Palsy
- NF ☐ Developmental Disability
- NH ☐ Migraines
- NI ☐ Headaches, Recurring
- NP ☐ Seizure Disorder ☐ Current ☐ History Type:
- NU ☐ Traumatic Brain Injury
- NO ☐ Other Neurological Condition:
  - ____

Transplant
- OD ☐ List organ:____________________________________

Mental or Behavioral Health
- PA ☐ Anxiety
- PC ☐ Depression
- PH ☐ Sleep Disorder
- PJ ☐ Other Mental or Behavioral Health Condition:
  - ____

Respiratory / Breathing
- RG ☐ Asthma – Current
- RH ☐ Asthma – Ever Diagnosed
- RA ☐ Asthma – Exercised Induced, Last Used Meds _________
- RE ☐ Reactive Airway Disease
  - ☐ Hospitalization/ER visit, Date _______________
- RF ☐ Other Respiratory Condition:
  - ____

Skin
- SB ☐ Eczema or Contact Dermatitis or Psoriasis
- SH ☐ Other Skin Condition:
  - ____

Renal / Kidney
- UH ☐ Please list:
  - ____

Ear / Hearing
- YA ☐ Chronic Ear Infections ☐ Currently ☐ Historically
- YB ☐ Hearing Impaired Hearing Aid/s Cochlear Implant
- YC ☐ Other Ear Condition:
  - ____

Eye / Vision
- YF ☐ Wears glasses / contacts
- YG ☐ Color Vision Deficit
- YD ☐ Visually Impaired
- YE ☐ Other Eye Condition:
  - ____

Other Health Concerns
- DB ☐ Please list:
  - ____

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AUBURN SCHOOL DISTRICT
ENGAGE • EDUCATE • EMPOWER

Student Name (Last,First)________________________Birthdate:_______________Grade:________ Gender:_______

MEDICATIONS

Please report all medications that your student takes at home and/or at school.

Is medication needed at **home**? ☐No ☐Yes Please list:
Is medication needed at **school**? ☐No ☐Yes Please list: **Complete REQUIRED paperwork for medication at school.**
State law requires written permission from guardian and a health care provider before any medication (prescription and over-the-counter) may be taken at school. Forms are available from your school office or on our district website and must be completed annually.

Medical Devices / Equipment / Procedures Example: Gastrostomy tube, VP Shunt, Catheterization, Vagal Nerve Stimulator, or Other Please Describe:	**Physical Activity or Mobility Issues / Assistive Equipment** Example: wheelchair, braces, or Other Please Describe:

To help us better understand your child, please complete the following:

Health/Developmental History:

Birth and Infancy: Birth Weight______ Was pregnancy Full Term? ☐ Yes ☐ No Duration of pregnancy__________________________

At what age was your child: Toilet trained? _________________ Walking?___________________ Talking?______________________

Hospitalizations?____

Serious Injuries?____

Specialist?____

What other information would be helpful for us to know regarding your child? Please share. ___________________________________

____

- ☐ I understand that the information I provided will be shared with appropriate school staff who need to know in order to provide for the health and safety of my student.
- ☐ If parents/guardians or authorized emergency contacts 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 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.
- ☐ **I understand that Washington law requires that my student's immunizations are complete or conditional before starting school.** I give permission to my child's school to add immunization information to the Immunization Information System to help the school maintain my child's school record.

Parent/Legal Guardian Signature: ____ **Date:** ________________________

Parent/Guardian phone/cell____ **Work** ________________________

Emergency contact/relationship____**Phone**__________________________________

Health Care Provider Name____**Phone**__________________________________

For Office Use only: Complete Immunization Records Complete IIS #_________________ IIS Copy Provided___ Medically verifiable records provided_____ COE_____ **or** Conditional status________ Parent signed acknowledgment **or** Out of compliance______