Student Health Information—Confidential Information

Auburn School District No. 408 • Auburn, Washington

Name _____ Date of Birth _____ Grade _____

School _____ Date_____ Gender (M/F) _____

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

		Comment
Is student taking any medication at home?	☐Yes ☐No	_____
Will medicine be taken during school?	☐Yes ☐No	_____

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

Any serious accidents/injuries/illness?	☐Yes ☐No	Describe/Date of event:_____
Asthma	☐Yes ☐No	*If yes, complete the Asthma section on reverse side of this page.*
Heart /Blood problems	☐Yes ☐No	_____
Diabetes	☐Yes ☐No	*If yes, read the Diabetes section on reverse side of this page.*
Vision/Hearing problems	☐Yes ☐No	Describe:_____
Seizures	☐Yes ☐No	_____
Endocrine problems	☐Yes ☐No	_____
Developmental/Autism	☐Yes ☐No	_____
Skeletal/Muscular problems	☐Yes ☐No	_____
Bowel/ Bladder/Digestion	☐Yes ☐No	_____
Attention Deficit Disorder	☐Yes ☐No	_____
Emotional/behavior problems	☐Yes ☐No	_____
Neurological	☐Yes ☐No	_____
Skin Condition	☐Yes ☐No	_____
Cancer/Neoplasm	☐Yes ☐No	_____
Food Allergies:	☐Yes ☐No	Allergic to:_____
		If yes, complete the Food Allergies section on the reverse side of this page.
Allergies:Bee/Insect/Other	☐Yes ☐No	Allergic to:_____
Severe allergy-Anaphylaxis: breathing difficulties or medication is needed	☐Yes ☐No	Allergic to:_____
		If yes, complete the Anaphylaxis – Severe Allergy section on the reverse side of this page.

Other health concerns/special needs/Medical Equipment? Please describe:

_____

_____

Is there a condition that would significantly limit PE? _____

Name of Physician _____ Phone # _____

Parent/Guardian _____ Home Phone # _____ Work # _____ Cell# _____

Parent/Guardian _____ Home Phone # _____ Work # _____ Cell# _____

I 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, learning and safety. I understand if a medical emergency were to occur and I cannot be reached the judgment of the school authorities will prevail and my student may be sent to the nearest medical facility. I assume full responsibility for the payment of any services rendered.

Signature _____ Date _____

Local emergency contact if parent unavailable	Emergency phone #	Second emergency contact phone #	Childcare phone #

Please turn over for more information and Parent/Guardian signatures

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 law defines "life-threatening condition" as a health condition that will put a child in danger of death during the school day if a medication or treatment order and a nursing 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.

Does your child have a Life Threatening Condition? ☐Yes ☐No

If this law applies to your student, please contact the School Nurse to help write your student's plan.

Asthma

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

1. At what age were they diagnosed with asthma? _____
2. How many days do 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 for asthma? (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 student's early warning signs of an asthma episode? (check all that apply)
   ☐ cough ☐ wheezing ☐ cold symptoms ☐ decreased exercise ☐ other (describe)
   _____
5. Does your student have and use a nebulizer machine at home? ☐Yes ☐No
6. Please provide the name of any medication(s) your student takes for their asthma at home.
   _____

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.**

Food Allergies

Is student able to self-monitor his/her food allergy? ☐Yes ☐No*

***If No, Diet Prescription form needs to be completed, see School Nurse/Child Nutrition**

Does Child Nutrition need to provide a Food Substitution? ☐Yes* ☐No

***If Yes, Diet Prescription form needs to be completed, see School Nurse/Child Nutrition**

_____ _____ _____

Signature of parent/guardian | Printed Name | Date

Anaphylaxis – <u>Severe</u> Allergy

If your student has an anaphylactic allergy as indicated on the front 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 ***If Yes, Medication Authorization Form from the Health Care Provider is required**.

Please contact the School Nurse to help implement your student's individualized healthcare and/or emergency action plan.

_____ _____ _____

Signature of parent/guardian | Printed Name | Date