Student Health History--Confidential Information

Auburn School District No. 408 • Auburn, Washington

Name _____ BD _____ School _____ Grade _____ Gender _____

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

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

Primary Care Provider _____ Phone number (_____)_____

Has your child ever received medical treatment by a specialist? ☐Yes ☐No Specialist's name _____

Date and reason for treatment _____

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

Birth and Infancy: Birth weight _____ Was Pregnancy Full Term? ☐Yes ☐No Duration of pregnancy _____

At what age was your child: toilet trained? _____ _____
walking? _____ _____
talking? _____ _____

Comment

Problem during pregnancy?.....☐Yes ☐No _____
Use of alcohol or drugs during pregnancy?.....☐Yes ☐No _____
Problem during labor/delivery?.....☐Yes ☐No _____
Concerns during child's first year?.....☐Yes ☐No _____
Birth defects? .....☐Yes ☐No _____

Please indicate if your child has any of the following:

Had a head injury/Lost consciousness.....☐Yes ☐No _____
Had a seizure.....☐Yes ☐No _____
A serious injury/accident.....☐Yes ☐No Date/Describe: _____
A serious illness.....☐Yes ☐No _____
Hospitalization/Surgery.....☐Yes ☐No Date/Describe: _____

Please indicate if your child has any of the following:

Asthma .....☐Yes ☐No *If yes, complete on reverse side of this page.* _____
Allergies (including food allergies).....☐Yes ☐No _____
Bee/insect/other allergy.....☐Yes ☐No _____
Diabetes.....☐Yes ☐No *If yes, complete on reverse side of this page.* _____
Endocrine problems .....☐Yes ☐No _____
Hearing problem .....☐Yes ☐No _____
Heart/blood condition .....☐Yes ☐No _____
Skeletal/muscular problem.....☐Yes ☐No _____
Bowel/bladder problems .....☐Yes ☐No _____
Vision problems.....☐Yes ☐No _____
Skin conditions.....☐Yes ☐No _____
Attention Deficit Disorder.....☐Yes ☐No _____
Emotional/behavioral problems .....☐Yes ☐No _____
Need for medical equipment .....☐Yes ☐No _____
A chronic condition or other problem.....☐Yes ☐No _____
Severe allergy/breathing difficulties……..…☐Yes ☐No **Allergic to:** _____ *If yes, complete on reverse side of this page.*

Medication: Name of Medication

Is medication needed at home?.....☐Yes ☐No _____
Is medication needed at school?.....☐Yes ☐No _____

Sate law <u>requires written</u> doctor and parent permission for taking <u>any</u> medication at school. Please obtain a form in the school office.
Thank you for completing this form. Healthy students make better learners.

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 and learning.

_____ _____
Parent/Guardian Signature *Date*

HS 830 pink (06/19)

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*