Student Health History--Confidential Information

Auburn School District No. 408 • Auburn, Washington

Name _____ BD _____ School _____ Grade _____ Sex ____

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

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

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

Date and reason for treatment _____

Primary Care Provider _____ Phone number (_____)_____

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 _____

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

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

Has your child ever had:

A serious head injury?	☐Yes ☐No	_____
Lost consciousness	☐Yes ☐No	_____
A seizure?	☐Yes ☐No	_____
A serious illness?	☐Yes ☐No	_____
A serious injury/accident?	☐Yes ☐No	_____
Surgery/hospitalization	☐Yes ☐No	_____

Does your child have a history of:

Any serious accidents/injuries/illness?	☐Yes ☐No	_____
Asthma	☐Yes ☐No	*If yes, complete the Asthma section on the reverse side of this page.*
Heart /Blood problems	☐Yes ☐No	_____
Diabetes	☐Yes ☐No	I*f yes, read the Diabetes section on reverse side of this page.*
Vision problems	☐Yes ☐No	_____
Seizures /Neurological	☐Yes ☐No	_____
Endocrine problems	☐Yes ☐No	_____
Hearing problems	☐Yes ☐No	_____
Skeletal/Muscular problems	☐Yes ☐No	_____
Bowel/ Bladder/Digestion	☐Yes ☐No	_____
Attention Deficit Disorder	☐Yes ☐No	_____
Emotional/behavior problems	☐Yes ☐No	_____
Medical Equipment	☐Yes ☐No	_____
Skin Condition	☐Yes ☐No	_____
Allergies	☐Yes ☐No	**Allergic to**:_____
Food Allergies:	☐Yes ☐No	**Allergic to**:_____
		If yes, complete the Food Allergies section on the reverse side of this page.
Bee/insect sting allergy	☐Yes ☐No	_____
Anaphylaxis - <u>Severe</u> allergy: 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.

Medication: Name of Medication

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

State 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.

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 of parent/guardian Date

Please turn over for more information and Parent/Guardian signatures

Asthma

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

1. How long has your child had asthma? _____ Years _____ Months
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

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

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.

_____	_____	_____
Signature of parent/guardian	Printed Name	Date