South Whidbey School District
Education to Navigate a Wider World

STUDENT HEALTH HISTORY FORM

Updated 5/11/2020

Parent/Guardian, please complete: **SCHOOL YEAR:** _____

Name of Student: _____

School: _____ **Grade:** _____ **Date of Birth:** _____

NAME OF CHILD'S DOCTOR/ NURSE PRACTITIONER _____ phone _____

LIFE THREATENING MEDICAL CONDITIONS: WA state law requires a medication/treatment order from a Health Care Provider if your child's health condition will *put your child in danger of death during the school day.* Written orders /information must be received by the School Nurse before your child can attend school. If appropriate, a care plan will be developed with the school nurse and parent/guardian.

DOES YOUR CHILD HAVE A LIFE THREATENING HEALTH CONDITION? ☐YES ☐NO

If Yes, Please describe: _____

☐ YES ☐ NO **Severe Allergic Reaction** (Bee Stings, Nuts, Shellfish, etc.): Anaphylaxis ☐ YES ☐ NO
DESCRIBE: _____

☐ YES ☐ NO ***OTHER* Allergic Reactions** Describe: _____

☐ YES ☐ NO **Asthma** **Will your child require asthma medication during school hours?** ☐ YES ☐ NO
Last Asthma episode requiring medical attention: _____

☐ YES ☐ NO **Diabetes** **TYPE:** _____ **SELF MANAGE:** ☐ YES ☐ NO **PUMP:** ☐ YES ☐ NO

☐ YES ☐ NO **Heart Condition** Describe: _____

☐ YES ☐ NO **Nosebleeds** Frequency: _____

☐ YES ☐ NO **Orthopedic Condition** Describe: _____

☐ YES ☐ NO **Seizure/Neurological Disorder** Describe: _____
Last episode requiring medical attention: _____

☐ YES ☐ NO **Migraines** Describe: _____

☐ YES ☐ NO **Bowel/Bladder Condition** Describe: _____

☐ YES ☐ NO **GI/Feeding Condition** Describe: _____

☐ YES ☐ NO **Behavioral/Emotional Concerns** Describe: _____

☐ YES ☐ NO **Vision Issues/Concerns** Describe: _____ Glasses: ☐ YES ☐ NO Contacts: ☐ YES ☐ NO
Approximate date of last eye exam _____

☐ YES ☐ NO **Hearing Issues/Concerns** Describe: _____ Hearing Aids: ☐ YES ☐ NO
Approximate date of last hearing exam _____

☐ YES ☐ NO **Speech/Language Issues/Concerns** Describe: _____

☐ YES ☐ NO **Other Health Concerns** Describe: _____

☐ YES ☐ NO **Does your child have any other conditions that would affect classroom performance or P.E. activities?**
If yes, please explain: _____

DAILY MEDICATION:

State law requires ***written authorization from a Health Care Provider and parent*** before **any** medication can be given at school. Medication forms are available at school or online.

☐ YES ☐ NO **Medication needed at school** (Specify): _____ (Authorization Needed)

☐ YES ☐ NO **Medication taken at home** (Specify): _____

This information is considered confidential. To ensure the health and safety of your child, it will be shared with school staff on a need to know basis. You agree to bring to the attention of the school any MAJOR CHANGES in the health of your student. You further give permission for South Whidbey School District staff to seek emergency medical services if necessary and to contact your child's healthcare provider and / or health department to exchange Immunization records.

Parent/Guardian (Printed Name): _____

Parent/Guardian Signature: _____

Telephone: (Home) _____ (Cell) _____ (Work)_____