

## ANNUAL HEALTH HISTORY FOR THE 2022-2023 SCHOOL YEAR

**RN** Reviewed

					(For office use only)
Student name:				Birth date:	
	Last	First	MI		
School:		Grade:		Student ID#	

We require an updated Annual Health History each school year, the information provided will be shared with pertinent staff members to ensure your student's safety at school.

Students with life-threatening conditions are required to have a medication/treatment order, medication and a health plan in place **PRIOR** to the start of school per <u>RCW 28A.210.320</u> and <u>WAC 392-380-045</u>. **Please contact your School Nurse.** 

## 1. Democratical conditions or medical concerns

**<u>YES</u>** the following medical conditions or medical concerns

	Life-Threatenin	g Conditions				
	(Please check the appropriate box and	d complete the questions after it.)				
Asthma	Does your child require a rescue inhaler at school?					
	Does your child use a rescue inhaler	more than once a week?				
	Has your child been hospitalized for a	s your child been hospitalized for asthma symptoms in the past year?				
Allergy	(Please check only if severe and epinephi	Please check only if severe and epinephrine is prescribed. Ex: peanuts, bees, tree nuts, etc.)				
	Allergen(s)					
Diabetes	Diagnosis date:	$\Box \text{ Type 1 OR } \Box \text{ Type 2 } \text{ CGM: } \Box \text{ Yes } \Box \text{ No}$				
		Ianages independently OR  Needs assistance				
Seizures	Туре: Но	w often:				
	Do your child's seizures require medi	ication?				
	Does your child require emergency seizure medication at school?					
	Any other medical condition	ons or medical concerns				
that could affe	fect your child at school. (Examples: m	edication allergies, ADHD, anxiety, encopresis,				
heart condition	ons, migraines, Crohn's, diet concerns,	genetic, history of concussions, Cerebral Palsy,				
	depression, PKU, enuresis, blood dis	sorders, etc.) Please list below.				

## 2. Medications (includes prescription, supplements, and over-the-counter medications)

My student requires medication(s) at school: 
NO 
YES\*

\*A physician order and signed parent consent must be on file, as outlined in EPS Policy 3416, before any medications will be allowed at school.

Medication(s) name		Diagnosis or symptoms requiring medication		
mation				
	Home:	Cell:		
Email:				
	Home:			
		Phone #2:		
Healthcare provider:		FAX:		
	Email: Email:	mation       Home:		

(Printed name and signature of parent/guardian completing form)

(Today's date)