



# ANNUAL HEALTH HISTORY FOR THE 2020-2021 SCHOOL YEAR

RN Reviewed

(For office use only)

Student name: _____ Last First MI	Birth date: _____
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 [RCW 28A.210.320](#) and [WAC 392-380-045](#). **Please contact your School Nurse.**

1.  **NO** medical conditions or medical concerns  
 **YES** the following medical conditions or medical concerns

Life-Threatening Conditions	
(Please check the appropriate box and complete the questions after it.)	
<input type="checkbox"/> <b>Asthma</b>	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 asthma symptoms in the past year? _____
<input type="checkbox"/> <b>Allergy</b>	(Please check only if <u>severe</u> and <u>epinephrine</u> is prescribed. Ex: peanuts, bees, tree nuts, etc.) Allergen(s) _____
<input type="checkbox"/> <b>Diabetes</b>	Diagnosis date: _____ <input type="checkbox"/> Type 1 OR <input type="checkbox"/> Type 2 CGM: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pump OR <input type="checkbox"/> Injections <input type="checkbox"/> Manages independently OR <input type="checkbox"/> Needs assistance
<input type="checkbox"/> <b>Seizures</b>	Type: _____ How often: _____ Do your child's seizures require medication? _____ Does your child require emergency seizure medication at school? _____
Any other medical conditions or medical concerns	
that could affect your child at school. (Examples: medication allergies, ADHD, anxiety, encopresis, heart conditions, migraines, Crohn's, diet concerns, genetic, history of concussions, Cerebral Palsy, depression, PKU, enuresis, blood disorders, etc.) <b>Please list below.</b>	
_____	

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

3. **Emergency contact information**

Parent/guardian 1: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_

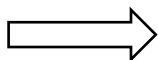
Work: \_\_\_\_\_ Email: \_\_\_\_\_

Parent/guardian 2: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Work: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone #1: \_\_\_\_\_ Phone #2: \_\_\_\_\_

Healthcare provider: \_\_\_\_\_ Phone: \_\_\_\_\_ FAX: \_\_\_\_\_



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

(Today's date)