For Office Use Only
Reviewed by RN _____

Everett Public Schools
Health Services
Annual Health History

The Everett Public Schools requests the parent/guardian complete an annual update of health information for each student at the start of each school year and/or at the time of registration.

Student Name: _____ Grade: _____ Student ID: _____
Student Lives With: _____ Home #: (_____) _____
Student Address: _____ Date of Birth: _____
Mother/Guardian Name: _____ Email: _____
Home #: (____) _____ Work #: (____) _____ Cell #: (____) _____
Father/Guardian Name: _____Email: _____
Home #: (____) _____ Work #: (____) _____ Cell #: (____) _____
Name of Licensed Health Care Professional: _____
Name of Clinic: _____ Clinic Phone #: (____) _____

State Required Immunizations:

_____ By initialing, I give Everett Public Schools permission to access vaccination information on the State Registry and enter the information in the student's record and in the district database.

☐ **There are no medical concerns** that may impact my child's participation in his/her educational program at this time or would be important information in the event of an accident, injury or illness at school.

OR

My student has the following medical condition(s):

Allergy:

☐ Allergy that is **NOT** life threatening**.** Allergic to _____
☐ Allergy that **IS** Life Threatening**.** Allergic to _____

Life saving medication (Epipen/Inhaler) and new orders are required before student can attend school. (See RCW and WAC below.)

Asthma:

☐ Asthma that does **NOT** require any medication at school and/or on field trips.
☐ Asthma that **DOES** require an inhaler/nebulizer at school and/or on field trips.

Life saving medication (Epipen/Inhaler) and new orders are required before student can attend school. (See RCW and WAC below.)

Diabetic: **Requires a new order** each year before the student can attend school. (See RCW and WAC below.)

☐ Diabetic Totally Independent ☐ Diabetic needing assistance Age Diagnosed: _____

Seizure Disorder: Age of first seizure: _____ Age of last seizure: _____

☐ Seizure Type _____ Seizure Medications _____

Medication: My student requires the medication listed below at school. (See RCW below.)

_____ _____ _____

RCW: State law (RCW 28A.210.260) requires a written request from a licensed health care professional prescribing within the scope of his/her prescriptive authority before any medications, prescriptions or over the counter products, may be dispensed at school. The required form is available from the school office or health center.

WAC: State law (WAC 392-380-045) requires that **PRIOR** to attendance at school, the parent/ guardian of each child with a life-threatening health condition including, but not limited to: diabetes, life threatening allergies (food, insect stings, etc.) and severe asthma, present both medication and treatment order(s) addressing the condition(s) to the school each school year prior to attending.

In the space below please indicate any additional medical information that school administrators or RNs should be aware of that may impact your child's educational program or school experience and would be important in the event of an accident, injury, or illness at school. (Use the reverse side if needed.)

_____

_____

If medication is required for 72 hour disaster preparedness, please contact the school.

Parent/Guardian Signature: _____ Date: _____

~ The information above may be shared with staff who have a legitimate educational interest. ~