EVERETT PUBLIC SCHOOLS

Annual Health History 2018 - 2019

RN Reviewed
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(For office use only)

The school requests a new annual health history be completed and returned each school year. Information provided will be shared with pertinent staff members to ensure student's safety at school.

Student Name: ____ **Birthdate**: ________________
Last First MI

School: ____________________________________ **Grade**:_______ **Student ID#**_______________

To ensure a safe environment at school, you are required to inform the nurse if your child has a life-threatening medical condition (listed below) PRIOR to your child attending the first day of school. A current medication order, health plan, and medication must be in place at the school each school year to ensure a safe environment for your student as required per state law (WAC 392-380-045).

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, as well as get medication authorization order prior to the start of school. ***This does not take the place of LHCP orders for school***.)

☐ ***Asthma*** Does your child use a rescue inhaler more than once a week?_________________________
Has your child been hospitalized for asthma symptoms in the past year?_________________
Has your child used steroids for asthma symptoms in the past year?____________________

☐ ***Allergy*** (Please check only if Severe and Epinephrine is prescribed. Ex: peanuts, bees, tree nuts, etc.)
Allergen(s)____

☐ ***Diabetes*** Diagnosis date:____________________ ☐Type 1 OR ☐Type 2 CGM: ☐ Yes ☐ No
☐Pump OR ☐Injections ☐Manages Independently OR ☐Needs Assistance

☐ ***Seizures*** 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.) **Please list below.**

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2. **Medications Required At School: (If your student requires medication at school, contact the health room for a medication order which is required per law RCW 28A.210.260)**

Medication Name	Dose	Diagnosis or Symptoms Requiring Medication

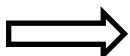
3. **Emergency Contact Information:**

Parent/Guardian 1:____________________________ *Home*:__________________ *Cell*:________________
Work:____________________ *Email*:____

Parent/Guardian 2:____________________________ *Phone #1*:________________ *Phone #2*:______________
Work:____________________ *Email*:____

Emergency Contact:____________________________ *Phone #1*:________________ *Phone #2*:______________

Health Care Provider:____________________________ *Phone*:__________________ *Fax*:________________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(Printed Name and Signature of Parent/Guardian Completing Form) (Today's Date)