ANNUAL HEALTH HISTORY
FOR THE _____ - _____ 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 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.)

❑ **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.**

_____

_____

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)

Adopted: December 2018