

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.

<b>Student Name:</b> _____	Last	First	MI	<b>Birthdate:</b> _____
<b>School:</b> _____	<b>Grade:</b> _____		<b>Student ID#</b> _____	

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 as 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.)

**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: \_\_\_\_\_  
 Does your child's seizures require medication? \_\_\_\_\_  
 Does your child require emergency seizure medication at school? \_\_\_\_\_

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**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 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)

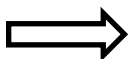
Medication Name	Dose	Diagnosis or Symptoms Requiring Medication

**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:** \_\_\_\_\_



\_\_\_\_\_  
 (Printed Name and Signature of Parent/Guardian Completing Form)

\_\_\_\_\_  
 (Today's Date)