



**Health History Form**

Student: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Sex:  M  F Birthday: \_\_\_\_\_ Age: \_\_\_\_\_ Current Medications: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Dear Parent and/or Guardian:

Please describe your child's health problems on this form. It is important to keep school personnel informed of any changes in health conditions or medication that could affect your child's school performance.

<b>ALLERGY</b> <input type="checkbox"/> Drug <input type="checkbox"/> Food <input type="checkbox"/> Insect <input type="checkbox"/> Other	Anaphylactic: <input type="checkbox"/> yes <input type="checkbox"/> no Describe Reaction:
<b>ASTHMA/RESPIRATORY PROBLEM</b> Cystic Fibrosis, etc.	Type: Special Needs:
<b>BLOOD DISEASE</b> Anemia, Hemophilia, etc	Type: Special Needs:
<b>CARDIAC</b> Pacemaker, arrhythmia	Type: Limitations
<b>DIABETES</b>	Medication: Special Needs:
<b>DIGESTIVE DISORDER</b> Food Intolerance, etc.	Type: Special Needs:
<b>HEARING IMPAIRMENT OR COMPLETE LOSS</b>	Describe: Special Needs:
<b>CANCER</b>	Type: Special Needs:
<b>NEUROLOGICAL PROBLEM</b> Hydrocephalus, Cerebral Palsy, etc.	Type: Special Needs:
<b>SEIZURE DISORDER</b> Epilepsy, etc.	Type: Medication: Special Needs:
<b>ORTHOPEDIC PROBLEM</b>	Type: Surgeries: Limitations:
<b>URINARY/KIDNEY DISORDER</b> Nephritis, Kidney stones, etc,	Type: Special Needs:
<b>VISION IMPAIRMENT OR COMPLETE LOSS</b>	Describe: Special Needs:
<b>SERIOUS ILLNESSES/INJURIES</b>	Describe: Special Needs:
<b>SKIN PROBLEMS</b> Eczema, etc.	Describe: Special Needs:
<b>OTHER HEALTH PROBLEMS</b>	Describe: Special Needs:

My child has none of the above conditions to my knowledge.

**Please circle the above condition(s), if any, that is life threatening.**

RCW 28A.210 requires physician orders and a nursing care plan in place before a student attends school.

**AUTHORIZATION FOR EMERGENCY PROCEDURE**

If the parents or guardian on the registration record cannot be reached at the time of a serious illness or injury, school authorities have my permission to seek necessary emergency treatment. If school authorities determine urgent or emergent care is needed, I authorize and direct the school authorities to take my child (properly accompanied) to the hospital or doctor most easily accessible. I understand that I will assume full responsibility for the payment of any services rendered.  Yes  No

Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_