Packet given to Parent
Date _____
Initial_____

Student Health History

To be completed by parent/guardian

Name of Student:_____ Date of Birth:_____ Grade: ____Sex: ☐ Male ☐ Female

☐ No ☐ Yes **Glasses/Contacts**, Date of last eye evaluation:_____

☐ No ☐ Yes **Hearing aids**, Date of last hearing exam:_____

Daily Medications

State law requires written permission from a Health Care Provider and parent before any medication (prescription or over-the-counter) can be given at school. A form is available from the school office.

☐ No ☐ Yes **Medication needed at school**(list):_____

☐ No ☐ Yes **Medication needed at home** (list):_____

Life Threatening Medical Conditions

Washington State law mandates that students with life-threatening health conditions, where the condition would "...put the child in danger of death during the school day", have medication/treatment orders and a nursing plan in place at school **before** your child can attend school. Forms are available from the school office.

Life Threatening Conditions (WILL require Health Care Provider orders)

Please check all that apply:

* Severe Allergy means diagnosed by a Health Care Provider and medication, such as an EpiPen, has been ordered

☐ No ☐ Yes ***Severe Allergic reaction to Nuts (list):_____** **Epi Pen ordered: ____ yes ____ no**

☐ No ☐ Yes ***Severe Allergic reaction to Bee Stings** **Epi Pen ordered: ____ yes ___ no**

☐ No ☐ Yes ***Other Severe Allergies-affecting school. Specify:_____** **Epi pen ordered: ____ yes ___ no**

☐ No ☐ Yes **Severe Asthma: <u>regularly takes</u> medication for asthmatic condition or hospitalized within last 5 years for asthmatic condition**

☐ No ☐ Yes **Diabetes**

☐ No ☐ Yes **Other**:_____

Potentially Life Threatening Conditions (MAY require Health Care Provider orders)

Please check all that apply and explain:

☐ No ☐ Yes **Asthma: takes medication only when needed**

☐ No ☐ Yes **Seizure Disorder:**

Type of Seizures and date of last Seizure: _____

☐ No ☐ Yes **Heart Condition**: _____

☐ No ☐ Yes **Behavioral/Emotional Concerns**: _____

☐ No ☐ Yes **Orthopedic Condition**: _____

☐ No ☐ Yes **Other Health Concerns**: _____

Does your child have any other condition that would affect his/her classroom performance or P.E. activities?

☐ No ☐Yes If yes, explain:_____

This information is considered confidential. It will be shared with school staff as needed during the time your child is enrolled in Kennewick School District in order to ensure the health and safety of your child, unless otherwise requested by you in writing.

Parent/guardian signature _____**Date**_____