Student Name: Grade: Sex: Date of Birth:

STUDENT HEALTH HISTORY FORM

This questionnaire is designed to aid school staff in anticipating any health concerns that might affect your child's safety or learning.

MEDICAL

Does your child have a doctor or nurse practitioner? Yes ___ No____
Name of child's doctor or nurse practitioner _____ phone number _____
In the past 12 months, did you have problems obtaining medical care for your child? Yes ____ No____

DENTAL

Does your child have a dentist? Yes ____No ____Name of child's dentist _____ phone number _____
Did your child receive a dental exam in the last 12 months? Yes___ No___ Don't know ____
Describe the condition of your child's teeth? Good ____ Fair ____Poor ____ Don't know ____
In the past 12 months, did you have problems obtaining dental care for your child? Yes ____ No____

INSURANCE

Does your child have medical insurance coverage? Yes ____ No ____ Don't know ____ Name of provider_____
Does your child have dental insurance coverage? Yes ____ No ____ Don't know ____ Name of provider_____
Does Medicaid insure him/her? (Apple Health for kids) Yes ____ No ____ Don't know ____

MEDICAL HISTORY

Have you ever been told by a physician or health care professional that your child has:

____ Asthma	____ Seizure disorder	____ Bleeding disorder	____ ADD/ADHD
____ Diabetes	____ Bone/muscle disease	____ Skin condition	____ Learning disability
____ Heart condition	____ Mental health condition (i.e., depression, anxiety, eating disorder)		____ Other_____

Does your child experience any of the following?

____ Nose bleeds	____Frequent ear aches	____Overweight for age	____Physical disability
____ Poor appetite	____Frequent stomach aches	____Frequent headaches	____Fainting spells
____ Tires easily	____Emotional concerns	____Underweight for age	____Other_____

Do any of the above condition(s) limit/effect your child at school?_____

LIFE-THREATENING CONDITIONS

Does your child have a life-threatening health condition? Yes *_____ No ____ Describe: _____

***If yes, a meeting with the school nurse is required. Washington State Law requires medication or treatment orders and a health care plan be in place prior to starting school.**

ALLERGIES

Plants _____ Animals _____ Food _____ Molds _____ Drugs _____ Bees _____ Other _____
Please describe the allergic reaction and the treatment for **each** checked allergy_____

_____

Do you plan for your child to receive school prepared meals? Yes *____ No ____
*an additional form must be completed for food allergies

MEDICATION

Does your child take any medication? Yes ____ No ____ If yes, name of medication: _____
Purpose _____Will medication be needed at school? Yes*____ No____

***If your child needs to take medication at school, please contact the office for the necessary authorization form. This form must be completed prior to any medication being brought to school.**

HEARING/VISION

Do you have concerns about your child's hearing? Yes ____ No ____ Does your child wear hearing aides? Yes ____ No ____
Do you have concerns about your child's vision? Yes ____ No ____ Does your child wear glasses or contacts? Yes ____ No ____

SPEECH/LANGUAGE

Do you have concerns about your child's speech and/or language? Yes ____ No ____ Do others have difficulty understanding your child? Yes ____ No ____If yes, please explain_____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I understand the information given above will be shared with appropriate school staff to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand I will assume full responsibility for payment of any transport or emergency medical services rendered.

Parent/Guardian Signature_____ Date _____