Child's name_____ Birth date _____ School _____ Grade _____
Physician_____ Preferred Hospital_____ Health Insurance Co._____

Health history: **Please complete both sides of this form**. This information is considered CONFIDENTIAL and is for use by the nurse, health room staff, teacher(s), building administrators, and others as needed to ensure your child's safety and protection at school.

Indicate below the medical conditions that may affect the student's school program or school performance.

STAFF: Notify school nurse immediately if parent/guardian lists condition in grey area.

Computer Code	**Health History/Condition**	**Current**		**Medications** *"Medication at School" form must be completed for school administration*	Check (√) if needed at school	**Comments**
		Yes	No			
EG & OB (staff enter both codes and list allergy type)	Anaphylactic allergy (life threatening) Insect ____ Bee ____ Food ____ Environmental _____			(service animals may be in buildings)		Specify source of allergy ie- peanuts, smoke, dogs etc
EK	Diabetes-Type 1					
NP	Seizure Disorder					Indicate type of seizure
RD	Asthma Severe					Specify factors contributing to flair-ups:
RB RC RE	Asthma- Mild ___ Moderate ___ Reactive Airway Dis. ___					Specify factors contributing to flair-ups:
EE ED EC AN	Allergy- mild/localized Insect ____ Bee ____ Food ____ Environmental _____ Medicine Allergy _____			(service animals may be in buildings)		Specify source of allergy ie- peanuts, smoke, dogs etc.
EJ	Cystic Fibrosis					
GG	Food Intolerance____					
CA CD CE	Cardiac Disorder_____ Heart Murmur____ Hypertension____					Specify condition if "Cardio-vascular - other":
BB	Hemophilia _____					

COMPLETE BACK SIDE AND SIGN/DATE- RETURN TO STUDENT'S SCHOOL OFFICE

Computer Code	Health History/Condition	Current Yes	No	Medications *"Medication at School" form must be completed for school administration*	Check (√) if needed at school	Comments
EA EU EO	Adrenal Disorder ___ Thyroid Disorder ___ Endocrine and/or metabolic disorder ____					Specify condition if "Endo/Metabol. – other":
NU	Traumatic Brain Injury					Indicate date of last injury:
PA	Anxiety Disorder					
YB YD	Hearing Impaired - R____L____ Visually impaired- R____L____					Exam date/results: Exam date/results:
MD MC ECC	Muscular dystrophy___ Juvenile Rheum Arthritis____ Eczema					Specify condition if "Musculo/skeltl – other":
NE	Cerebral Palsy					
UA UE GF	Chronic Renal Failure___ Incontinence—bladder Encopresis - bowel					Specify condition if "Genito/Urinary- other":
TA TI	Neoplasm (cancer) blood and or circulatory____ Neoplasm (cancer) other___					Specify condition if "Neoplasm (cancer) – other":
NS	Spina Bifida					
NB	ADD/ADHD					
NC	Autism					

Other Conditions or Comments: _____

No child may take medication (prescription or over-the-counter) at school without a completed medication administration form (s) including signature by Health Care Provider and/or parent/guardian. Forms may be picked up in the office or at your provider's. **Please provide information to school in writing if you have special instructions regarding religious beliefs.**

Do you need **health insurance** for your child? **Apply faster** online at www.wahealthplanfinder.org or you may request a paper form application from the school office.

AUTHORIZATION FOR EMERGENCY PROCEDURE: If the parent(s)/guardian named above cannot be reached at the time of an emergency, and if immediate observation or treatment is urgent in the judgment of the school authorities, I authorize and direct the school authorities to contact emergency medical aide and send the student to the hospital or doctor most easily accessible. I understand that I will assume full responsibility of the payment of any services rendered.

Parent/guardian Signature_____ **Date**_____