

### 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/affect 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 \_\_\_\_\_