English

DO NOT WRITE IN THE SPACE BELOW – FOR ENROLLMENT OFFICE USE ONLY
STUDENT ID# _____ SY/SCHOOL# _____/_____

SEATTLE PUBLIC SCHOOLS

STUDENT HEALTH INFORMATION

Information on this form is to be filled out (updated) for each new school year. Please complete both sides of this form and return to your school nurse as soon as possible.

Name: _____ Birthdate: _____ Sex: M / F
Last First MI (circle)

School: _____ Grade: _____ Date: _____

SPECIAL HEALTH CARE PLANNING

If anything checked for SPECIAL HEALTH CARE PLANNING, send form to Health Services (MS 31-650 or call 206-252-0750)

☐ **Diabetes – Date of diagnosis: _____ My student has:** ☐ insulin pump ☐ insulin pen ☐ injected insulin

☐ **Seizure Disorder –** My student needs emergency medication for **Seizures**. Name of medication: _____

☐ **Special Health Care Planning -** My child has special health care needs such as – wheelchair, tube feedings, breathing tube, catheter, intravenous tubes or other. Please describe your child's condition(s): _____
_____

☐ **My child has NONE of the health concerns/conditions listed above.**

LIFE THREATENING CONDITIONS

If anything checked for LIFE THREATENING, send form to your child's school

Asthma *Severe - (If this box is checked, please answer the following questions):
Yes ☐ No ☐ Does child use rescue inhaler routinely for asthma symptoms?
Yes ☐ No ☐ Has your child been hospitalized for asthma in the past year?
Yes ☐ No ☐ Has your child used steroids (prednisone) for asthma symptoms in the past year?
(If mild or moderate asthma, see box below 'Health History -Non-Life Threatening'

Allergy/Anaphylaxis - *Severe, with Epi Pen/ Auvi-Q prescription (for example: food, insect stings)
Allergen(s): _____
Other: _____

☐ **My child has NONE of the health concerns/conditions listed above.**

ALERT TO PARENTS/GUARDIANS: *The school **must** know of **LIFE THREATENING** conditions (for example severe allergy with anaphylaxis, diabetes, asthma) **prior to the start of school**, as these may require an Individualized Health Plan (per RCW 28A.210.320). Contact your School Nurse or Health Services to begin the process for a student health care plan and/or medications at school.*

HEALTH CONDITIONS

Check any of these conditions which your child has or has had:

☐ ADD/ADHD	☐ Blood Disorder	☐ Depression/Anxiety	☐ Heart Problems	☐ Serious Injury
☐ Allergies *mild or moderate (circle one)*	☐ Bowel/Bladder	☐ Dental	☐ Orthopedic/Bone	☐ Vision Concerns
☐ Asthma *mild or moderate (circle one)*	☐ Cancer	☐ Hearing	☐ Social/Emotional/Behavioral	☐ Other

If you have checked any of the above medical conditions/concerns, please explain: _____
_____
_____

Has the student ever visited an emergency room or hospital for the medical issue? YES / NO (circle) If yes, date: _____
_____

☐ **My child has NONE of the health concerns/conditions listed above.**

PLEASE SEE OTHER SIDE

MEDICATIONS

List any medications taken by student:|

Medication Taken: _____ For_____ ☐At Home ☐At School
Medication Taken: _____ For_____ ☐At Home ☐At School
Medication Taken: _____ For_____ ☐At Home ☐At School

Students requiring medications during the school day (herbal, over the counter, or prescription) MUST have a written provider order and written parent consent and health care provider must be on file. Contact your school office for MEDICATIONS AT SCHOOL form and MUTUAL EXCHANGE form.

SHARING HEALTH CARE INFORMATION

In order to provide a safe and healthy environment for your child, the school nurse may need to share information about your student's health condition with teachers and essential school staff. If you have questions, please contact your school nurse or Health Services.

CONTACT INFORMATION

Please provide correct & current contact numbers, and update with School Nurse if needed.

Name of Health Care Provider: _____Phone: _____

Name of Dentist: _____Phone: _____

	1. Parents/Guardians	2. Parents/Guardians
Names:		
Home phone:		
Cell phone:		
Work phone:		
Email:		
Additional Information:		

_____
Student's Name

_____ _____
Parent/Guardian Name (Printed) Signature

_____ _____
Relationship to Student Date

Nurse Review Date/Initial:_____