



HEALTH REGISTRATION FORM

Student's Name _____ Grade _____ Birth Date _____ M / F

Parent/Guardian's Name & Address _____

Street _____ City _____ Zip Code _____

Home phone _____ Parent/Guardian's work phone _____

Parent/Guardian's work phone _____ Parent/Guardian's cell phone _____

Parent/Guardian's cell phone _____ Pager/Alternate number _____

Emergency contact phone _____ Relationship to Student _____

Emergency contact name _____

Last school attended (school name) _____

Name and phone number of Doctor or Clinic _____ Last seen _____

HEALTH HISTORY

Does the student have ...	NO	YES	Does the student have ...	NO	YES
... ADD/ADHD?			... emotional concerns?		
... allergies?			... epilepsy seizures?		
... anaphylactic allergy? ** see other side			... hearing problems?		
... anemia?			... heart problems?		
... asthma?			... vision problems?		
... bladder problems?		contacts?		
... bowel problems?		glasses?		
... dental problems?					
... depression or anxiety?			Has the student ever had a serious injury?		
... diabetes? * see other side			Are there any other concerns?		

If the answer to any of the above is YES, has the student ever visited the emergency room or hospital for the issue? Please explain: _____

Does the student take medication of any kind? _____ If yes, please explain _____

Will the student need to take medication at school? _____ Students requiring medication (prescription or nonprescription) at school **MUST** have a written physician order and written parent consent. Please contact the school secretary or go on-line to <http://www.seattleschools.org/area/healthservices/forms/pforms.xml> for consent forms.

Please complete other side . . .

* DIABETES

If your student has diabetes, he or she may be affected by a new state law that requires that individual health care plans be implemented for all students with diabetes. If your student is diabetic please contact the school nurse to help write your student's plan.

** ANAPHYLAXIS

If your student has an anaphylactic allergy, please answer the following questions:

1. What is your student allergic to _____
2. What are your student's symptoms _____
3. When was your student's last reaction _____
4. Has your student been prescribed epinephrine or Epi-pen? _____
If yes, please contact your school nurse at _____

The District has implemented an anaphylaxis management strategy. You should contact the school nurse to help write your student's individual care plan. If your student has been prescribed epinephrine (Epi-pen), under a new state law a treatment order must be kept at school before your student will be allowed to attend school.

LIFE THREATENING CONDITIONS

State law requires that students who have a life threatening condition **MUST** have both medical authorization and medication at school before that student will be allowed to attend school. The types of medications that may be required under this law include, but are not limited to, meter-dose inhalers, Epi-pens, and medication for uncontrollable seizures. If this new law may apply to your student, please contact the school nurse to create an individual health care plan.

For the safety of your student, the school nurse may need to share information about your student's health condition with teachers and staff in order to ensure appropriate care of your student. If you have questions about this practice, please contact the school nurse.

Name (printed)

Signature

Relationship to Student

Today's Date