



SEATTLE
PUBLIC
SCHOOLS

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.

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

English

STUDENT HEALTH INFORMATION

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:

- | | | | | |
|--|---|---|--|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Serious Injury |
| <input type="checkbox"/> Allergies mild or moderate (circle one) | <input type="checkbox"/> Bowel/Bladder | <input type="checkbox"/> Dental | <input type="checkbox"/> Orthopedic/Bone | <input type="checkbox"/> Vision Concerns |
| <input type="checkbox"/> Asthma mild or moderate (circle one) | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing | <input type="checkbox"/> Social/Emotional/Behavioral | <input type="checkbox"/> 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: _____