



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 <i>mild or moderate (circle one)</i> | <input type="checkbox"/> Bowel/Bladder  | <input type="checkbox"/> Dental             | <input type="checkbox"/> Orthopedic/Bone             | <input type="checkbox"/> Vision Concerns |
| <input type="checkbox"/> Asthma <i>mild or moderate (circle one)</i>    | <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.**

**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: \_\_\_\_\_

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

\_\_\_\_\_  
 Student’s Name

\_\_\_\_\_  
 Your Name (printed)

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Relationship to Student

\_\_\_\_\_  
 Today’s Date

Nurse Review Date/Initial: \_\_\_\_\_