

PUYALLUP SCHOOL DISTRICT

HEALTH HISTORY

NAME:	DOB:	GRADE:	DATE:
PARENT/GUARDIAN:		RELATIONSHIP TO STUDENT:	

LIFE THREATENING CONDITIONS

Does your child have a life threatening health condition?
Yes** _____ No _____
 Specify _____
****If yes, you must schedule a meeting with the School Nurse prior to student starting school. Washington State Law requires that a medication, treatment, and/or healthcare plan is in place prior to starting school.**
 Does your child have a current Emergency Action Plan and/or 504? _____
 Does your child ride the bus? Yes ___ No ___ Route # _____

HEALTH CONCERNS

Have you ever been told by a health care professional that your child has:

___ **ADD/ADHD** (circle one)
 ___ **Allergies** Type _____
 Medication required **Yes*** ___ No ___ Type _____
 Describe reaction _____
 ___ **Asthma** Uses inhaler **Yes*** ___ No ___
 Exercise induced Yes ___ No ___
 ___ **Bowel/Bladder Issues** Type _____
 ___ **Diabetes** *Meeting with the School Nurse is required*
 ___ **Dental Issues** Type _____
 ___ **Drug/alcohol treatment** Year _____
 ___ **Emotional Concerns** (circle)
 Depression/ Anxiety/Eating Disorder/Other _____
 ___ **Frequent cold/sore throats/earache** (circle)
 ___ **Headaches** Frequency _____
 ___ **Head injury** Concussion Yes ___ No ___
 Date _____ Lost consciousness Yes ___ No ___
 ___ **Hearing** (circle) Aids Preferential Seating Tubes
 ___ **Heart Condition** _____
 Restrictions/Limitations _____
 ___ **Major Illness/Surgery/Hospitalization** Year _____
 Describe _____
 ___ **Neurological conditions** _____
 ___ **Nose bleeds** Frequency _____
 ___ **Other bleeding conditions** _____
 ___ **P.E .Limitations** _____
 For what reason? _____
 ___ **Seizure Disorder** Describe type _____
 Last seizure _____
 ___ **Skin Condition** _____
 ___ **Speech Difficulty/Therapy** (circle)
 ___ **Stomach aches/cramps/tires easily** (circle)
 ___ **Vision Problem** Contacts _____ Glasses _____
 Reading _____ Distance _____ Both _____
 ___ **Other Concerns** _____

MEDICATION

Does your child take any medication? Yes ___ No ___
 If Yes, name of medication _____
 Purpose: _____
 Will the medication be needed at school? **Yes*** ___ No ___
***For medications to be administered at school, Washington State Law and District policy #3416 requires a written Physician’s Order for Medication and parent permission to be completed each school year.**

DEVELOPMENTAL HISTORY

Was there a health problem/handicap at birth?
 Yes/No Please describe: _____
 Normal Pregnancy: Yes/No Normal Delivery: Yes/No
 If no, explain: _____
 Birth Weight: _____ Talked words (age) _____
 Walked (age) _____
 Do you feel your child’s development has been equal to other children’s? Yes/No If No, why not?

 Do you have concerns about your child’s hearing, vision, or speech? Yes ___ No ___ Specify _____
 Last medical exam: Date: _____ Provider: _____
 Last eye exam: Date: _____ Provider: _____
 Last Dental exam: Date: _____ Provider _____
 Does your child have medical insurance? Yes ___ No ___
 Does your child have dental insurance? Yes ___ No ___
 Is your child covered by Medicaid? (Healthy Options, DSHS, “medical coupons”) Yes ___ No ___
 Is there any other health related information that school staff should know?

 Washington State Immunization Law 28A.31.118 requires that a Certificate of Immunization be completed for each child attending school or day care center.

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I understand that 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 medical emergency, I authorize and direct school staff to send my child to the most accessible hospital or physician. I understand that I will assume full responsibility for payment of any transport or emergency medical services rendered.

 Parent/Guardian Signature Date