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 <u>prior</u> 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 Normal Delivery: Yes
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 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 (Electronically Signed) Date

(2/11)

NURSE'S HEALTH APPRAISAL

Student Name_____ **Birth date** _____

School Year													
Date													
Grade													
Height													
Weight													
Vision	R L 20/ 20/	R L 20/ 20/	R L 20/ 20/	R L 20/ 20/	R L 20/ 20/	R L 20/ 20/	R L 20/ 20/	R L 20/ 20/	R L 20/ 20/	R L 20/ 20/	R L 20/ 20/	R L 20/ 20/	R L 20/ 20/
--w/o glasses													
--w/glasses													
--both eyes													
--Referred													
--Pref. Seating													
Hearing	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
--Referred													
--Pref. Seating													
Dental													
--Orthodontia													
Nurse Eval.													
B/P													
Nurse (last name)													

Code: N-Normal R-Refer to notes

CIS on file:____ Meets Requirements: ____ Exemption: ____ If yes, for: _____