



# Health Information

Student Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Teacher \_\_\_\_\_ Grade: \_\_\_\_\_

### Medical History:

#### Allergy

Nuts  Bees  Food (specify \_\_\_\_\_)  Seasonal  Other \_\_\_\_\_

Did you seek medical attention for this allergy?  Yes  No

Epi Pen required?  Yes  No

#### Asthma

Medications:  Inhaler  Nebulizer  Other (specify \_\_\_\_\_)

Hospitalization for asthma?  Yes  No

If yes? When: \_\_\_\_\_

#### Diabetic

Date of diagnosis: \_\_\_\_\_ Insulin dependent  Yes  No

Insulin administration by:  Pen  Pump  Syringe

Current HCP orders for students in WA state completed?  Yes  No

Please check if you have been diagnosed by a health care provided for:

- Heart condition
- Migraines
- Orthopedic conditions
- Seizure disorder
- ADD/ADHD
- Eczema
- Kidney disease
- Physical disability
- Other: \_\_\_\_\_
- Frequent ear infections/tubes
- Speech issues

Is medication needed for any condition: At home?  Yes  No At school?  Yes  No

Name of medication: \_\_\_\_\_

*All medications, OTC and prescription (i.e. Tylenol, Advil, cough drops), require a doctor's order to be used at school.*

List of operations, injuries, hospitalizations or prolonged illness	Dates

Recommended physical activity (please check one):  Full Activity  Modified/Restricted Activity

If restrictions, please explain: \_\_\_\_\_

Check all that apply to your child:  Glasses  Contact lenses  Hearing aids

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date