Medical Lake School District #326
Health History Form

Student's Name_____ Sex M / F Birthdate_____ Age_____
Grade_____Date Entered_____Last School Attended_____
Parent/Guardian Name_____Phone_____

Parent/Guardian: Please describe your child's current health condition(s) on the form below. It is important that you keep the school informed of any changes in health or medication which would affect your child at school. School regulations require a HEALTH CARE PROVIDER/PARENT permission form for taking **ANY** medications at school. Please contact the school office for any required forms.

RCW 28A.210 requires that students with life-threatening conditions have health care provider orders and a nursing care plan in place before a student attends school. These forms are available in the school office.

ADD/ADHD, BEHAVIORAL/MENTAL HEALTH RELATED PROBLEM (autism, anxiety, depression etc.)	TYPE: MEDICATION:	MEDICATION AT SCHOOL YES / NO **HEALTH CARE PROVIDER ORDERS REQUIRED FOR MEDICATION AT SCHOOL**
ALLERGIES: FOODS_____ INSECTS_____ MEDICATIONS_____ OTHER_____	MILD MODERATE SEVERE LIFE THREATENING (ANAPHYLAXIS)-EPINEPHERINE REQUIRED	**SEVERE REACTIONS REQUIRE HEALTH CARE PROVIDER ORDERS, NURSING CARE PLAN AND MEDICATION**
ASTHMA	MILD MODERATE SEVERE LIFE THREATENING (ANAPHYLAXIS)- EPINEPHERINE REQUIRED	MEDICATION AT SCHOOL YES / NO **HEALTH CARE PROVIDER ORDERS, NURSING CARE PLAN AND MEDICATION REQUIRED**
BLOOD DISORDER (anemia, sickle cell, etc.)	TYPE:	
CARDIAC (heart murmur, hypertension etc.)	TYPE:	
DIABETES TYPE 1 OR TYPE 2	MEDICATION INSULIN- INJECTION PEN PUMP	**TYPE 1 REQUIRES HEALTH CARE PROVIDER ORDERS AND NURSING CARE PLAN**
DIGESTIVE DISORDER (colitis, lactose intolerance, celiac, etc.)	TYPE:	**DIET PRESCRIPTION FORM NEEDED FOR FOOD SUBSTITUTIONS**
ENDOCRINE SYSTEM PROBLEMS	TYPE:	
EPILEPSY OR SEIZURE DISORDER	TYPE: MEDICATION:	MEDICATION AT SCHOOL YES / NO **HEALTH CARE PROVIDER ORDERS AND NURSING CARE PLAN REQUIRED**
MALIGNANCY/CANCER	TYPE:	
NEUROLOGICAL PROBLEM (hydrocephalus, cerebral palsy, etc.)	TYPE:	
MUSCULOSKELETAL PROBLEMS (arthritis, muscular dystrophy, etc.)	TYPE:	
RESPIRATORY PROBLEM (cystic fibrosis, tuberculosis, etc.)	TYPE:	
SKIN PROBLEMS (eczema, psoriasis, etc.)	TYPE:	
URINARY/KIDNEY DISORDER	TYPE:	
VISION OR HEARING PROBLEMS	IMPAIRMENT LOSS	GLASSES CONTACTS HEARING AID COCHLEAR IMPLANT
OTHER HEALTH PROBLEMS	TYPE:	

☐ **No health problems to my knowledge**

The information that you provide will be shared with those in the district who have a need to know in order to provide a safe and healthy environment for your child.

Parent/Guardian Signature_____ Date_____