North Thurston Public Schools
305 College Street NE
Lacey, Washington 98516-5390

Student Support Services
www.nthurston.k12.wa.us

Please fill out this information sheet and return it to school.

STUDENT HEALTH HISTORY

We would appreciate your help updating your child's health information so that we can take the best possible care of him/her at school.

Student's Name _____ Birthdate/Age _____ Sex ___ Grade/Teacher _____

Parent/Guardian _____ Phone _____ Cell _____

Email Address _____

Name/Address of Licensed Health Professional _____ Phone _____

Student Medical History: Does your student have any of the following? Please check:

	Allergies (see below)		Diabetes (see below)		Seizure disorder (see below)
	Asthma (see below)		Dietary concerns		Skin condition/eczema
	Behavioral concerns		Frequent headaches/migraines		Stomach/intestinal concerns
	Bladder or bowel concerns		Hearing problem		Urinary/kidney disorder
	Blood disorder		Heart condition (see below)		Vision problems
	Brain (injury, conditions, surgery, etc.)		Physical disabilities		Vision problems- Glasses /Contacts?

Other _____

_____

Allergies:

□ Bee sting allergy □ Food allergy (specify) _____ □ Other allergies (specify) _____

□ Please describe the allergic reaction and treatment _____

_____

***Has your child ever been advised by your licensed healthcare professional to keep an EpiPen?** □ Yes □No

If you checked yes to EpiPen above, your student must have a physician order and EpiPen in place before attending school.

Asthma: Please check applicable triggers: □ allergies □ exercise □ irritants □ respiratory infections □ weather (cold air)

If you checked yes to asthma above, please complete an asthma treatment plan (ASP-1) prior to attending school.

Life Threatening Condition: If you student has a life threatening condition, such as: **Diabetes, Heart Condition or Seizure Disorder**

Please contact the school nurse for additional documentation required prior to attending school.

Other Health Information:

Does your student have a health problem that affects his/her daily living or school participation? □ Yes □ No

If yes, please explain: _____

_____

List any significant injuries or operations: _____

Is your child required to take medications? □Yes □ No Is your student required to take medication at school? □Yes □ No

Please list all medication names and reason for taking: _____

_____

Policy for Administering Medication to Students

Oral medications, prescriptive or over the counter, may be administered to students only with the written permission of the parent or guardian and a licensed health care provider. I understand that licensed health care providers have *Authorization for Administration of Medication at School* forms available in their office or the district will send them upon request.

Any other special needs or concerns? _____

If your child is injured at school we will: Contact 911

Contact parent or emergency contact person if at all possible

I consent to the release of medical information related to my child to school personnel to ensure his/her safety at school. I understand that it will be my responsibility to arrange payment for medical care should my child be injured. I have read and understand this form.

Parent/Guardian signature _____ Date _____