TO BE COMPLETED BY PARENT/GUARDIAN

HEALTH HISTORY

3418F2

(Last, First): _____ DOB:_____ ☐ M ☐ F Grade:_____ ID #:_____
Student Name

This information is needed to plan an appropriate program for your student and to prepare for any emergency situation if one should arise. ***Washington state law requires that LIFE-THREATENING CONDITIONS such as ANAPHYLAXIS, DIABETES, SEIZURES or ASTHMA have a health plan completed prior to the first day of school. Please contact the building nurse as soon as possible to ensure all paper work is complete.**

Medical History (check all that apply) or ☐ No health condition at this time (please sign below).

Congenital Conditions
A_ ☐ Please List _____

Hematology (Blood)
BB ☐ ***Hemophilia** _____
BC ☐ Sickle Cell Anemia _____
BD ☐ Other Blood Condition _____

Cardiovascular/Heart Conditions
C_ ☐ Please List _____

Endocrine, Allergy, Immune System, Metabolic, and Nutritional
ED ☐ Allergy-Food _____
EE ☐ Allergy–Insect _____
E- ☐ Other Allergy _____
EG ☐ ***Anaphylactic Condition (EpiPen)** _____
EJ ☐ Cystic Fibrosis _____
EK/L ☐ ***Diabetes Type 1** ☐ ***Diabetes Type 2**
EM ☐ Allergy to Medication(s) _____
EN ☐ Eating Disorder _____
EU ☐ Thyroid Disorder _____
E_ ☐ Other Endocrine, Immune, or Metabolic Disorder _____

Gastrointestinal, Dental, and Oral Conditions
GA/J/K ☐ Celiac Disease ☐ Crohn's ☐ Irritable Bowel
GH/L ☐ Gastroesophageal Reflux ☐ Lactose Intolerance
GI ☐ Other _____
GM ☐ Liver Disease _____
GD ☐ Dental Condition _____
GN ☐ Oral Condition _____

Musculoskeletal and Connective Tissue
MC ☐ Juvenile Idiopathic Arthritis _____
MD ☐ Muscular Dystrophy _____
MF ☐ Osgood-Schlatter _____
MH ☐ Scoliosis _____
M_ ☐ Other _____

Skin and Subcutaneous Tissue
SB ☐ Contact Dermatitis (Eczema) _____
S_ ☐ Other _____

Nervous System
☐ ADHD-Inattentive ☐ ADHD-Hyperactive/Impulsive
NB ☐ ADHD-Combined, Diagnosed by: _____
NC ☐ Autism Spectrum Disorder _____
NE ☐ Cerebral Palsy _____
NF ☐ Developmental Delay _____
NH/I/J ☐ Migraines ☐ Headaches ☐ Shunt
NL ☐ Intellectually Disabled _____
NN ☐ Paralysis _____
NP ☐ ***Seizure Disorder** _____
NQ ☐ Sensory Condition _____
NS ☐ Spina Bifida _____
NT ☐ Spinal Cord Injury _____
NU ☐ Traumatic Brain Injury _____

Behavioral Health Conditions
PH ☐ Sleep Disorder _____
PI ☐ Tourette Syndrome _____
P_ ☐ Other _____

Respiratory
RA ☐ Exercise-Induced Bronchospasm ☐ ***Inhaler**
RH ☐ Asthma – ever-diagnosed
RG ☐ ***Asthma – current** ☐ ***Inhaler**
RE ☐ Reactive Airway Disease _____
RF ☐ Other _____

Neoplasms (Cancer/Tumors)
T_ ☐ Please List _____

Renal and Genitourinary
UB/U- ☐ Chronic Urinary Tract Infection ☐ Urinary Reflux
UC ☐ Dysmenorrhea (painful menstrual periods) _____
U_ ☐ Other _____

Eye and Ear
YB ☐ Hearing Impaired _____
YA/YC ☐ Chronic Ear Infections _____ ☐ Ear Condition _____
YD ☐ Visually Impaired _____
YE ☐ Eye Condition _____
YF ☐ Wears Glasses _____ Last Eye Eval: _____

Is medication needed at home? ☐ No ☐ Yes Please list: _____
Is medication needed at school? ☐ No ☐ Yes Please list: _____
Hospital Preference: _____ ☐ **No Blood Products**

If parent/guardian or authorized emergency contact cannot be reached at the time of a medical emergency, and if immediate care is urgent in the judgment of school authorities. I authorize and direct the school authorities to send the student to the hospital or doctor most accessible. I understand that I will assume full responsibility for the payment of any services rendered. I understand that the information given above will be shared with appropriate school staff that needs to know in order to provide for the health and safety of my student. I give my consent for Snohomish School District staff to obtain and enter vaccine dates into the WAIIS to maintain my student's immunization record.

Date:_____ **Parent/Guardian Signature:** _____ Phone:_____