

(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 /Genetic Conditions**

AG  Other \_\_\_\_\_  
 AJ  Fetal Alcohol Spectrum Disorder \_\_\_\_\_

**Hematology (Blood)**

BB  **\*Hemophilia** \_\_\_\_\_  
 BC  Sickle Cell Anemia \_\_\_\_\_  
 BD  Other Blood Condition \_\_\_\_\_

**Cardiovascular/Heart Conditions**

CG  Other \_\_\_\_\_

**Endocrine, Allergy, Immune System, Metabolic, and Nutritional**

EB  Other Allergy \_\_\_\_\_  
 ED  Allergy-Food \_\_\_\_\_  
 EE  Allergy-Insect \_\_\_\_\_  
 EG  **\*Anaphylactic Condition (EpiPen)** \_\_\_\_\_  
 EJ  Cystic Fibrosis \_\_\_\_\_  
 EK/L  **\*Diabetes Type 1**  **\*Diabetes Type 2** \_\_\_\_\_  
 EM  Allergy to Medication(s) \_\_\_\_\_  
 EN  Eating Disorder \_\_\_\_\_  
 EO  Other Endocrine, Immune, or Metabolic Disorder \_\_\_\_\_  
 EU  Thyroid Disorder \_\_\_\_\_

**Gastrointestinal, Dental, and Oral Conditions**

GA/J/K  Celiac Disease  Crohn's  Irritable Bowel  
 GD  Dental Condition \_\_\_\_\_  
 GG  Food Intolerance \_\_\_\_\_  
 GH/L  Gastroesophageal Reflux  Lactose Intolerance  
 GI  Other \_\_\_\_\_  
 GM  Liver Disease \_\_\_\_\_  
 GN  Oral Condition \_\_\_\_\_

**Musculoskeletal and Connective Tissue**

MB  Other \_\_\_\_\_  
 MC  Juvenile Rheumatoid Arthritis \_\_\_\_\_  
 MD  Muscular Dystrophy \_\_\_\_\_  
 MF  Osgood-Schlatter \_\_\_\_\_  
 MH  Scoliosis \_\_\_\_\_

**Skin and Subcutaneous Tissue**

SB  Contact Dermatitis (Eczema) \_\_\_\_\_  
 SH  Other \_\_\_\_\_

**Is medication needed at home?**  No  Yes Please list: \_\_\_\_\_

**Is medication needed at school?**  No  Yes Please list: \_\_\_\_\_

**Hospital preference:** \_\_\_\_\_

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 and information into the WAIS to maintain my student's immunization record.

Date: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_ Phone: \_\_\_\_\_

**Nervous System**

ADHD-Inattentive  ADHD-Hyperactive/Impulsive  
 NB  ADHD-Combined, Diagnosed by: \_\_\_\_\_  
 NC  Autism Spectrum Disorder \_\_\_\_\_  
 ND  Central Nervous System Conditon Other \_\_\_\_\_  
 NE  Cerebral Palsy \_\_\_\_\_  
 NF  Developmental Disability \_\_\_\_\_  
 NH/I/J  Migraines  Headaches  Shunt  
 NN  Paralysis \_\_\_\_\_  
 NP  **\*Seizure Disorder** \_\_\_\_\_  
 NQ  Sensory Condition \_\_\_\_\_  
 NS  Spina Bifida \_\_\_\_\_  
 NT  Spinal Cord Injury \_\_\_\_\_  
 NU  Traumatic Brain Injury \_\_\_\_\_

**Behavioral Health Conditions**

PA  Anxiety \_\_\_\_\_  
 PC  Depression \_\_\_\_\_  
 PH  Sleep Disorder \_\_\_\_\_  
 PI  Tourette Syndrome \_\_\_\_\_  
 PJ  Other \_\_\_\_\_

**Respiratory**

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

**Neoplasms (Cancer/Tumors)**

TI  Other \_\_\_\_\_

**Renal and Genitourinary**

UB  Chronic Urinary Tract Infection \_\_\_\_\_  
 UC  Dysmenorrhea (painful menstrual periods) \_\_\_\_\_  
 UD  Genito-Urinary Condition Other \_\_\_\_\_  
 UH  Renal Condition 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: \_\_\_\_\_

# EMERGENCY INFORMATION

Please print student's last name: \_\_\_\_\_ Bus #: \_\_\_\_\_

*In order to provide immediate and safe care for your child and carry out your wishes in case of injury or illness at school, we require the following information. Please fill out completely. **Please Print.***

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grad Year: \_\_\_\_\_  
Last First Middle Initial

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Street City Zip

Lives with:  Parents  Mother only  Mother/Stepfather  Guardian  Father only  Father/Stepmother

Other: \_\_\_\_\_

Parent/Guardian Name 1: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Parent/Guardian Name 2: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Primary language spoken at home:  English  Spanish  Other: \_\_\_\_\_

Day Care Provider (if applicable): \_\_\_\_\_ Phone: \_\_\_\_\_

**Please complete the following if student has a non-custodial parent who can make emergency decisions for the student and receive copies of records involving this student, including newsletters, grade reports, correspondence, etc.**

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Street City Zip

Parent/Guardian Name 1: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Parent/Guardian Name 2: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**In addition to the parent/guardian, if you cannot be reached, the school may call and release your child to any of the following:**

Name 1: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name 2: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name 3: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Please list all children in Snohomish School District this year. (Please list students in this school first.)**

Last Name	First Name	School	Grade

Signature of Parent or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Please check here if any information on this form is new.

**\*\*\*THIS FORM MUST BE RETURNED AT REGISTRATION**