

**ANNUAL HEALTH HISTORY
FOR THE _____ - _____ SCHOOL YEAR**

 RN Reviewed _____
 (For office use only)

Student name: _____			Birth date: _____		
Last	First	MI			
School: _____			Grade: _____		Student ID# _____

We require an updated Annual Health History each school year, the information provided will be shared with pertinent staff members to ensure your student's safety at school.

Students with life-threatening conditions are required to have a medication/treatment order, medication and a health plan in place **PRIOR** to the start of school per [RCW 28A.210.320](#) and [WAC 392-380-045](#). **Please contact your School Nurse.**

1. ☐ **NO** medical conditions or medical concerns
☐ **YES** the following medical conditions or medical concerns

Life-Threatening Conditions	
(Please check the appropriate box and complete the questions after it.)	
☐ Asthma	Does your child use a rescue inhaler more than once a week? _____ Has your child been hospitalized for asthma symptoms in the past year? _____ Has your child used steroids for asthma symptoms in the past year? _____
☐ Allergy	(Please check only if <u>severe</u> and <u>epinephrine</u> is prescribed. Ex: peanuts, bees, tree nuts, etc.) Allergen(s) _____
☐ Diabetes	Diagnosis date: _____ ☐ Type 1 OR ☐ Type 2 CGM: ☐ Yes ☐ No ☐ Pump OR ☐ Injections ☐ Manages independently OR ☐ Needs assistance
☐ Seizures	Type: _____ How often: _____ Do your child's seizures require medication? _____ Does your child require emergency seizure medication at school? _____
Any other medical conditions or medical concerns	
that could affect your child at school. (Examples: medication allergies, ADHD, anxiety, encopresis, heart conditions, migraines, Crohn's, diet concerns, genetic, history of concussions, Cerebral Palsy, depression, PKU, enuresis, blood disorders, etc.) Please list below.	

2. **Medications** (includes prescription, supplements, and over-the-counter medications)

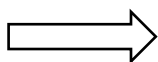
My student requires medication(s) at school: ☐ NO ☐ YES*

*A physician order and signed parent consent must be on file, as outlined in EPS Policy 3416, before any medications will be allowed at school.

Medication(s) name	Diagnosis or symptoms requiring medication

3. **Emergency contact information**

Parent/guardian 1: _____ **Home:** _____ **Cell:** _____
Work: _____ **Email:** _____
Parent/guardian 2: _____ **Home:** _____ **Cell:** _____
Work: _____ **Email:** _____
Emergency contact: _____ **Phone #1:** _____ **Phone #2:** _____
Healthcare provider: _____ **Phone:** _____ **FAX:** _____



(Printed name and signature of parent/guardian completing form)

(Today's date)