

RN check:  
Input EHR: \_\_\_\_\_

**San Juan Island School District  
Health History Form**

Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Sex: M  F  Birth Date: \_\_\_\_\_ School: \_\_\_\_\_

Preferred Gender:

This information is needed to provide appropriate health services to your child during the school day and to prepare for any emergency situation should one arise. The school nurse may contact you with additional questions.

**Does the student have** (check all that apply):

**Please Explain any "YES" Answers**

**No Health Concerns**

- |  |                            |                            |       |
|--|----------------------------|----------------------------|-------|
| Allergies (food, pollen, medications, etc.)  | <input type="checkbox"/> N | <input type="checkbox"/> Y | _____ |
| <b>*Anaphylaxis (life threatening allergy)</b>   | <input type="checkbox"/> N | <input type="checkbox"/> Y | _____ |
| <b>*Asthma</b>   | <input type="checkbox"/> N | <input type="checkbox"/> Y | _____ |
| <b>*Seizures</b>   | <input type="checkbox"/> N | <input type="checkbox"/> Y | _____ |
| <b>*Diabetes</b>   | <input type="checkbox"/> N | <input type="checkbox"/> Y | _____ |
| Heart Condition  | <input type="checkbox"/> N | <input type="checkbox"/> Y | _____ |
| Bowel or Bladder concerns  | <input type="checkbox"/> N | <input type="checkbox"/> Y | _____ |
| ADD / ADHD (please circle one)   | <input type="checkbox"/> N | <input type="checkbox"/> Y | _____ |
| Migraines  | <input type="checkbox"/> N | <input type="checkbox"/> Y | _____ |
| Chronic condition or disability  | <input type="checkbox"/> N | <input type="checkbox"/> Y | _____ |
| Other health concerns  | <input type="checkbox"/> N | <input type="checkbox"/> Y | _____ |
| Has your student ever had chest pain,<br>shortness of breath, fainting, or passing out<br>during or after exercise | <input type="checkbox"/> N | <input type="checkbox"/> Y | _____ |
| Mental /Emotional concerns / diagnosis   | <input type="checkbox"/> N | <input type="checkbox"/> Y | _____ |

**Please Have School Nurse Call Me**

**\*LIFE THREATENING CONDITIONS - RCW 28A.210.320**-Children with life-threatening conditions, requires medication or treatment orders as a prerequisite for children with life-threatening conditions to attend public schools. The law defines "life-threatening condition" as a health condition that will put the child in danger of death during the school day, if a medication or treatment orders and a nursing care plan are not in place.

**MEDICATIONS**

Is medication taken regularly at home?  N  Y \_\_\_\_\_

Is medication needed at school?  N  Y \_\_\_\_\_

\*\*State laws requires written permission from a licensed health care provider and parent/guardian before any medication, prescription or over-the-counter, may be taken at school. A form is available from the school office or at [www.sjisd.wednet.edu](http://www.sjisd.wednet.edu)

**Health History Informed Consent**

This disclosure of student health information with the school is limited to the information necessary to serve the student's health or education interest. Your signature gives permission for the school nurse to share this information with school staff on a need-to-know basis for precautions, procedures, and emergency plans to protect your child at school. You further agree to bring to the attention of the school any **major changes** in the physical condition of your student.

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

Print Parent / Guardian Name \_\_\_\_\_ Phone# \_\_\_\_\_