

HOCKINSON SCHOOL DISTRICT
Student Health History 2017-2018

To be completed by parent/guardian (Mark those that apply)

Student Name: _____ Date of Birth: _____ Grade: _____ Male Female

Home phone #: _____ Work#: _____ Teacher: _____

Life Threatening Medical Conditions:(check all that apply)State law requires a medication/treatment order from a Licensed Health Professional before your child can attend school if a life threatening condition exists. A form is available from the school office.

Yes No **SEVERE allergic reaction to Nuts** - specify: _____

Yes No **SEVERE allergic reaction to Bees** - specify: _____

Yes No **Other SEVERE allergies-affecting school.** specify: _____

Asthma REQUIRES DAILY medication for asthmatic condition OR has been hospitalized OR had emergency room/urgency care clinic visits within the past year for asthmatic condition.

Yes No **Diabetes, diagnosed at age:** _____

Yes No **Medication or food allergies:** _____

Yes No **Other:** _____

Possible Life Threatening Medical Conditions: (check all that apply)

State law requires a medication/treatment order from a Licensed Health Professional if your child's health condition *will put your child in danger of death during the school day*. Orders must be in place before your child can attend school. A form is available from the school office.

Yes No **Asthma - takes medication only when needed. Medication:** _____

Yes No **Seizure Disorder:**
Types of Seizures and date of last Seizure: _____

Yes No **Heart Condition:** _____

Yes No **Blood Disorder:** Specify: Hemophilia Anemia Other _____

Does your child have any other diagnosed condition that would affect his/her classroom performance or P.E. activities?

Yes No If yes, explain: _____

Yes No **Behavioral / Emotional Concerns:** _____

Yes No **Attention Deficit Disorder:** Specify: ADD ADHD Medication Taken: _____

Yes No **Orthopedic Condition:** _____

Yes No **Wears Glasses / Contacts:** Date of Last Eye Evaluation: _____

Yes No **Wears Hearing Aids:** Date of Last Hearing Exam: _____

Daily Medication

State law requires written permission from a Licensed Health Professional and parent before any medication (prescription or over-the-counter) can be given at school. A form is available from the school office.

Yes No **Medication Needed at School** - specify: _____

Yes No **Medication Needed at Home-** specify: _____

This information is considered confidential. It will be shared with school staff only as needed during the time your child is enrolled in Hockinson School District in order to ensure the health and safety of your child, unless otherwise requested by you in writing.

Parent/guardian signature: _____ Date: _____