

HOCKINSON SCHOOL DISTRICT  
**Student Health History 2018-2019**

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: \_\_\_\_\_