Health History Information

Partners in Education
Tukwila School District

Does your Student have any kind of health condition?
Yes Please continue to fill in form below.
No You do not need to complete the form. Thank you.

The following questionnaire is designed to help the School Nurse plan for the Health and Safety of your son/daughter while at school. Please Print Clearly

Students Name_____ Date of Birth_____

Parent/ Guardian Name_____

I acknowledge that this information will be maintained in my student's school record and shared with staff on a need-to-know basis to provide a safe and healthy environment for my student.

Please contact me by telephone at this number _____

A **Life Threatening Condition** is a health condition that will put the child in danger of death during the school day if a medication or treatment order and a health plan are not in place. Children with **Life Threatening Health Conditions** such as **Severe Bee Sting, Severe Food Allergies, Asthma, Diabetes, Seizures,** or other at risk conditions are **required** to have a **Medication Treatment Order and an Individual Health Plan** in place before they start school. **These orders must be updated before the first day of school each year.**

Does your child have a **Life Threatening Health Condition?** Yes No

Does your Child have Medical Insurance? Yes No If No would you like help finding insurance? Yes No

Has your child been hospitalized for a Health Condition? Yes No

If Yes, When_____ For_____

Please **Circle** any of these conditions you student has or has had:

ADD Blood Disorder Convulsions/Seizures Hearing Problem Orthopedic/Bone

ADHD Bowel Concerns In Counseling Social/Emotional/Behavioral Heart Disease

Autism Cancer Diabetes Kidney/Bladder Disease Vision Problem

Allergic to _____ **Severe?** Yes No Epi Pen? Yes No

Asthma Yes No How would you rate the severity of the students Asthma?

(not severe) 1 2 3 4 5 6 7 8 9 10 (severe)

Hospitalized for Asthma? Yes No When_____

Uses inhaler? Yes No Uses Nebulizer? Yes No

Triggers that may start an Asthma episode? Please **circle** all that apply.

Exercise	Strong Odor or Fumes	Pollens
Respiratory Infections	Dust	Molds
Change in temperature	Animal Dander	Food

What are this students initial Asthma symptoms?_____

How do they progress?_____

How often are as needed medications used? (# of times per day/week/month) _____

Does the student use any of the following aids for managing asthma? Circle all that apply.

Peak flow meter Spacer Spacer with mask Other
(specify)_____

Can your son/daughter identify when they are experiencing Asthma symptoms? Yes No

What does this student do to manage his/her own health condition?_____

_____

What can the nurse/teacher help with at school?_____

_____

List any medications taken by the student now, including inhalers, pills, insulin.

Medication_____ For _____ Home School

Medication _____ For _____ Home School

Students requiring Medication at School must have Authorization Form completed prior to start of school. You may ask the school staff for the form. It must be completed by your Health Care Provider and signed by a Parent/Guardian.

Signature of Parent/Legal Guardian_____

Date_____