Student Health History

This questionnaire is designed to aid school staff in anticipating any health concerns that might affect your child's learning

Student's Name _____
First *Middle* *Last*
Grade: _____ **Sex:** _____ **Date of Birth**: _____

MEDICAL
Does your child have a doctor or nurse practitioner? Yes ___ No____
Name of child's doctor or nurse practitioner _____ phone number _____
In the past 12 months, did you have problems obtaining medical care for your child? Yes ____ No____

DENTAL
Does your child have a dentist? Yes ____No ____Name of child's dentist _____ phone number _____
Did your child receive a dental exam in the last 12 months? Yes___ No___ Don't know___
Describe the condition of your child's teeth? Good ____ Fair ____Poor ____ Don't know ____
In the past 12 months, did you have problems obtaining dental care for your child? Yes ____ No____

INSURANCE
Does your child have medical insurance coverage? Yes ____ No ____ Don't know ____ Name of provider_____
Does your child have dental insurance coverage? Yes ____ No ____ Don't know ____ Name of provider_____
Does Medicaid insure him/her? (Healthy Options, DSHS, "medical coupon") Yes ____ No ____ Don't know ____

MEDICAL HISTORY
Have you ever been told by a physician or health care professional that your child has:

____ Asthma	____ Seizure disorder	____ Bleeding disorder	____ ADD/ADHD
____ Diabetes	____ Bone/muscle disease	____ Skin condition	____ Learning disability
____ Heart condition	____ Mental health condition (i.e. depression, anxiety, eating disorder)		____ Other_____

Does your child experience any of the following?

____ Nose bleeds	____Frequent ear aches	____Overweight for age	____Physical disability
____ Poor appetite	____Frequent stomach aches	____Frequent headaches	____Fainting spells
____ Tires easily	____Emotional concerns	____Underweight for age	____Other_____

Do any of the above condition(s) limit/effect your child at school?_____

LIFE THREATENING CONDITIONS
Does your child have a life threatening health condition? Yes *****_____ No _____ Describe: _____

***If yes, a meeting with the school nurse is required. Washington State Law requires that medication or treatment orders and a health care plan be in place prior to starting school.**

ALLERGIES
Plants _____ Animals _____ Food _____ Molds _____ Drugs _____ Bees _____ Other: _____
Please describe the allergic reaction and the treatment_____

MEDICATION
Does your child take any medication? Yes ____ No ____ If yes, name of medication: _____
Purpose: _____Will medication be needed at school Yes ____ No____

If your child needs to take medication at school please contact the office for the necessary authorization form. This form must be completed prior to the administration of any medication at school.

HEARING/VISION
Do you have concerns about your child's hearing? Yes ____ No ____ Does your child wear hearing aides? Yes ____ No ____
Do you have concerns about your child's vision? Yes ____ No ____ Does your child wear glasses or contacts? Yes ____ No ____

SPEECH/LANGUAGE
Do you have concerns about your child's speech and/or language? Yes ____ No ____ Do others have difficulty understanding your child? Yes ____ No ____If so, please explain _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I understand that the information given above will be shared with appropriate school staff on a need to know basis to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand that I will assume full responsibility for payment of any transport or emergency medical services rendered.

Parent/Guardian Signature Date

From: *Guidelines for Care of Students with Anaphylaxis (March 2009) OSPI Publication 09-0009*