

Meadow Glade Adventist Elementary School

Student Health History Form

This form is to be completed by the student's parent/guardian. This form must be completed prior to the student starting school.
IF ANY INFORMATION ON THIS FORM CHANGES, A NEW FORM MUST BE PROVIDED TO THE SCHOOL NURSE.

Student Name (Last, First, Middle): _____ Birth Date: ___/___/___ Grade: _____
Physician Name: _____ Phone: _____ Date of last well exam: _____
Dentist Name: _____ Phone: _____ Date of last dental exam: _____

DOES YOUR STUDENT HAVE ANY OF THE FOLLOWING **LIFE THREATENING CONDITIONS**? (Please check all that apply)

- ASTHMA** requiring daily medication and/or rescue medication
Name of Medication(s): _____ Asthma Triggers: _____
Have you had to seek emergency care for your student in the past 12 months? yes no
- ALLERGY/ANAPHYLAXIS** requiring Epi-pen and/or medication(name) _____
Allergen/Reaction: _____
Allergen/Reaction: _____
Allergen/Reaction: _____
- SEIZURE DISORDER**
Types of seizure _____ How often occurs _____
Emergency medication required at school yes no medication name _____
- FOOD OR MEDICATION ALLERGY** requiring emergency assistance at school
(specify): _____
- DIABETES** Type _____ Age Diagnosed _____ Has insulin pump? _____ CGM? _____
- OTHER** _____
- MY STUDENT HAS NONE OF THE ABOVE LISTED CONDITIONS**

★ Please note - per Washington state law RCW28A.210.320 and school policy, any condition checked above **requires** treatment and medication orders from a licensed healthcare provider, non-expired medication(s) at school, and health care plan in place **before** the start of school. The school nurse may contact you for further information. YOUR STUDENT MAY BE EXCLUDED FROM SCHOOL WITHOUT THESE ITEMS IN PLACE. Medication forms for prescription and over-the-counter medications are available on the school website under documents/forms, or from the school nurse. Please contact the school nurse with any questions.

Please check if your student has any of the following conditions:

- Heart condition (explain) _____
- Blood Disorder Hemophilia Anemia Other _____
- Any diagnosed condition that will affect classroom performance and/or physical activities: _____
- Behavioral/Emotional Concerns: _____
Takes Medication yes no Medication name: _____
- ADD/ADHD Takes Medication yes no Medication name: _____
- Orthopedic Condition: _____
- Headaches / Migraines Takes Medication yes no Medication name: _____
- Food sensitivities / Dietary restrictions: _____
- Wears glasses/contact lenses Date of last eye exam: _____
- Wears hearing aides has hearing loss Ear affected Right Left Both Date of last hearing exam: _____

Daily Medication - State law requires written permission from a Licensed Health Professional and parent before any medication can be given at school. Forms are available on the school website or from the school nurse. Please do not send medication to school with your student, including cough drops.

I understand that the above information is considered confidential and may be shared with appropriate school staff as needed to ensure the safety and wellbeing of my student during the school day. I authorize school staff to request emergency medical services for my student if needed.

Parent Signature _____ **Print name** _____ **Date** _____