HEALTH REGISTRATION FORM

Student's Name _____ Grade ___ Room ___ Birth Date _____ M / F
Last *First*

Parent/Guardian's Name(s) _____

Address _____ Home Phone _____

Mother's work phone _____ Father's work phone _____

Mother's cell phone _____ Father's cell phone _____

Emergency contact name _____ Emergency contact phone _____

Doctor or clinic _____ Phone _____

HEALTH HISTORY

Does the student have …	No	Yes	**Does the student have …**	No	Yes
• ADD/ADHD? ***circle one***			• emotional concerns?		
• allergies? ***list:***			• epilepsy seizures?		
• anaphylactic allergy? ***see other side**			• hearing problems?		
• anemia?			• heart problems?		
• asthma? ***list triggers*** • *Indicate: Mild, Moderate, or Severe*			• vision problems?		
• bladder problems?			• contacts?		
• bowel problems?			• glasses?		
• dental problems?					
• depression or anxiety? ***circle one***			Has the student ever had a serious injury?		
• diabetes? ***see other side***			Are there any other concerns?		

If the answer to any of the above is YES, please explain. _____

_____

If the answer to any of the above is YES, has the student ever visited the emergency room or hospital for this condition? Please explain: _____

_____

Does the student take medication of any kind? _____ If yes, please explain _____

_____

Will the student need to take medication at school? _____ Students requiring medication (prescription or nonprescription) at school **MUST** have a written physician order and written parent consent. Please contact the school secretary or go on-line to http://www.seattleschools.org/area/healthservices/forms/pforms.xml for consent forms.

Please complete other side . . .

* DIABETES

If your student has diabetes, s/he may be affected by a state law that requires that individual health care plans be implemented for all students with diabetes. If your student is diabetic please contact the school nurse to help write your student's plan.

** ANAPHYLAXIS: A severe allergic reaction. Symptoms may include tightness of throat or chest, breathing difficulty, swelling of lips, tongue, throat, or eyes, generalized itching, rash or hives, color changes in the nails, lips, or skin, abdominal cramps or vomiting, seizures and loss of consciousness.

If your student has an anaphylactic allergy, please answer the following questions:

1. What is your student allergic to _____
2. What are your student's symptoms _____
3. When was your student's last reaction _____
4. Has your student been prescribed epinephrine or Epi-pen? _____
   If yes, please contact your school nurse.

The District has implemented an anaphylaxis management strategy. You should contact the school nurse to help write your student's individual care plan. If your student has been prescribed epinephrine (Epi-pen), under a new state law a treatment order must be kept at school before your student will be allowed to attend school.

LIFE THREATENING CONDITIONS

State law requires that students who have a life threatening condition **MUST** have both medical authorization and medication at school before that student will be allowed to attend school. The types of medications that may be required under this law include, but are not limited to, meter-dose inhalers, Epi-pens, and medication for uncontrollable seizures. If this new law may apply to your student, please contact the school nurse to create an individual health care plan.

For the safety of your student, the school nurse may need to share information about your student's health condition with teachers and staff in order to ensure appropriate care of your student. If you have questions about this practice, please contact the school nurse.

_____ _____
Name (printed) Signature

_____ _____
Relationship to Student Today's Date

MAY WE CONTACT YOUR CHILD'S HEALTH CARE PROVIDER?

If yes, please go to http://www.seattleschools.org/area/healthservices/forms/exchange.pdf for the Mutual Exchange form or get one from your school nurse.

Adopted August, 2002, revised 4/7/05