STUDENT HEALTH HISTORY

TO BE COMPLETED BY PARENT/GUARDIAN

IHP Packet given to Parent
Date _____
Initial _____

Name of Student:_____ Date of Birth:_____Grade: _____Sex: ☐ Male ☐ Female

VISION AND HEARING

☐ No ☐ Yes **Glasses/Contacts** Date of last eye exam:_____

☐ No ☐ Yes **Hearing aids** Date of last hearing exam:_____

MEDICATION

☐ No ☐ Yes Medication needed at home (list):_____

☐ No ☐ Yes **Medication needed at school* (list):**_____

***Daily Medications Needed at School – Medication at School form required**
State law requires written permission from a Health Care Provider and parent before any medication can be given at school. (prescription/over-the-counter). A form is available from the school office.

LIFE THREATENING CONDITIONS -WILL require Health Care Provider order & Individual Health Plan (IHP)

Life Threatening Medical Conditions
Washington State law mandates that students with life-threatening health conditions, where the condition would "...put the child in danger of death during the school day", have medication/treatment orders and an Individual Health Plan (IHP)/nursing plan in place at school **before** your child can attend school. Forms are available from the school office.

(*note a SEVERE allergy *is one that has been diagnosed by a Health Care Provider and medication has been ordered)*

☐ No ☐ Yes ***Severe Allergic reaction to Nuts/other foods(list):**_____**EpiPen ordered: ___yes ___no**

☐ No ☐ Yes ***Severe Allergic reaction to Bee Stings EpiPen ordered: ___yes ___no**

☐ No ☐ Yes ***Other Severe Allergies-affecting school. Specify:**_____ **EpiPen ordered: ___yes ___no**

☐ No ☐ Yes **Severe Asthma: regularly takes medication for asthma, or has been hospitalized within last 5 years for asthmatic condition**

☐ No ☐ Yes **Diabetes**

☐ No ☐ Yes **Other:**_____

POTENTIALLY LIFE THREATENING CONDITIONS *The school nurse may contact the parent/guardian for further information. Healthcare provider orders, IHP and/or nursing care plan may be needed.*

☐ No ☐ Yes **Asthma: takes medication only when needed**

☐ No ☐ Yes **Seizure Disorder Type of Seizures and date of last Seizure**_____

☐ No ☐ Yes **Heart Condition:** _____

☐ No ☐ Yes **Food intolerances/sensitivities:**_____

☐ No ☐ Yes **Behavioral/Emotional Concerns:** _____

☐ No ☐ Yes **Orthopedic Condition:** _____

☐ No ☐ Yes **Other Health Concerns:** _____

Does your child have any other condition that would affect his/her classroom performance or P.E. activities?

☐ No ☐Yes If yes, explain:_____

This information is considered confidential. It will be shared with school staff as needed, including the school health alert, during the time your child is enrolled in Kennewick School District in order to ensure the health and safety of your child, unless otherwise requested by you in writing.

Parent/guardian signature _____**Date**_____