Stanwood-Camano School District **School Year _____**

Student Health Concerns

Student Name _____ Grade_____ Birth date_____

Parent/Guardian Name_____Parent/Guardian Email_____

Home Phone_____Work/Cell Phone_____

Medical History:

Has your student ever had a serious accident, operation, or illness? (nature and approx. date) _____

_____

Please check any **HEALTHCARE PROVIDER DIAGNOSED** health concerns that your student has. If your student does not have any health concerns, simply check the box that says "No Health Concerns at this time".

☐ **No Health Concerns at this time**

ALLERGIES

☐ Bee or insect allergy
Reaction ☐Mild ☐ Severe/Life Threatening
Symptoms_____
Treatment_____

☐ Seasonal allergies

☐ Food allergy
List foods _____
Reaction ☐Mild ☐ Severe/Life Threatening
Symptoms_____
Treatment_____

☐ Latex allergy

☐ Drug allergy _____

☐ *Has EpiPen

NEUROLOGICAL

☐ Seizure Disorder Type: _____

☐ ADD ☐ ADHD

☐ Autism Spectrum Disorder

☐ Headaches ☐ Migraines

☐ Other: _____

DIGESTION/ELIMINATION

☐ Bowel control problems

☐ Irritable Bowel Syndrome

☐ Bladder incontinence

☐ Other: _____

DIABETES

☐ Type I ☐ Type II

VISION/HEARING

☐ Vision deficit ☐ Glasses/Contacts

☐ Hearing deficit ☐ Hearing Aid

CARDIOVASCULAR

☐ Heart Murmur ☐ Arrhythmia _____

☐ Cardiac Disorder_____

☐ Heart Birth Defect

☐ Other: _____

RESPIRATORY

☐ Asthma – mild Intermittent symptoms, infrequently uses rescue inhaler, no interference with normal activity

☐ Asthma – moderate Persistent symptoms, uses rescue inhaler, some activity limitation

☐ Asthma – severe Daily symptoms, uses rescue inhaler several times a day, normal activities extremely limited

☐ Has Inhaler at? ☐ *School ☐ Home

Triggers of asthma
☐Exercise ☐ Dust ☐ Pollen ☐ Respiratory illness
☐ Change in temperature ☐ Other_____

☐ Other:_____

MUSCULOSKELETAL/SKIN

☐ Cerebral Palsy

☐ Other Musculoskeletal condition_____

☐ Other Skin conditions: _____

BEHAVIORAL HEALTH

☐ Obsessive Compulsive Disorder

☐ Oppositional Defiant Disorder

☐ Bipolar Disorder

☐ Depression

☐ Other:_____

CONGENITAL

☐ Down Syndrome

☐ Other: _____

HEMATOLOGICAL

☐ Hemophiliac ☐ Sickle Cell ☐ Other:_____

Medication:

Medication student takes daily **at home** (list medications):_____

Medication **at school** (list medications):_____

If medication is needed at school, complete and return an "Authorization for Medication at School" form. Health care provider AND parent/guardian signatures are required. Form can be obtained from school nurse, office, or district website.

I authorize the disclosure of health information on this form to be shared with the school nurse or other staff responsible for my student during the school day.

Parent/Guardian Signature:_____ Date:_____