Health History

To be completed by parent/guardian

Student Name
(Last,First): _____ **DOB:** _____ ❒ **M** ❒ **F** **Grade:** _____

Please check any health concerns that apply. Information you provide on this form will replace and/or update any previous health information received with the exception of Life-Threatening Health Condition (requires written Health Care Provider and parent documentation to remove.)

Does your child have a *Life-Threatening Health Condition? ☐ **Yes** ☐ **No** (OB)

Health History *(check all that apply)* OR ❒ No Health Conditions at this time **(please sign form)**.

Congenital Condition
- AG ❒ Please List _____

Hematology (Blood)
- BB ❒ ***Hemophilia** _____
- BA ❒ Anemia _____
- BD ❒ Other Blood Condition _____

Cardiovascular/Heart Conditions
- CA ❒ Please List: _____

Endocrine, Allergy, Immune, Metabolic, Nutritional
- ED ❒ Allergy – Food _____
- EE ❒ Allergy - Insect _____
- EM ❒ Allergy - Drug _____
- EB ❒ Other Allergy _____
- EG ❒ ***Anaphylactic Condition (Epi-pen)***
- EK/L ❒ ***Diabetes Type I** ❒ Diabetes Type II
- EN ❒ Eating Disorder _____
- EO ❒ Other Endocrine, Immune, or Metabolic Disorder _____

Gastro-Intestinal, Dental, and Oral Conditions
- GA/J/K ❒ Celiac Disease ❒ Crohns ❒ Irritable Bowel
- GH/L ❒ Gastro Esophageal Reflux ❒ Lactose Intolerance
- GF ❒ Encopresis
- GI ❒ Other _____
- GM ❒ Liver Disease _____
- GD ❒ Dental Condition _____
- GN ❒ Oral Condition _____

Musculoskeletal and Connective Tissue
- MC ❒ Juvenile Rheumatoid Arthritis _____
- ME ❒ Musculoskeletal other _____

Skin and Subcutaneous Tissue
- SB ❒ Contact Dermatitis (Eczema) _____
- SH ❒ Other _____

Renal and Genitourinary
- UB/E ❒ Chronic Urinary Tract Infection ❒ Incontinence
- UC ❒ Dysmenorrhea (painful periods)
- UD ❒ Other

Nervous System
- NA/C ❒ Asperger's Syndrome ❒ Autism
- NB ❒ ADHD/ADD Diagnosed by: _____
- NE ❒ Cerebral Palsy _____
- ND ❒ Central Nervous System Other: _____
- NH/I/J ❒ Migraines ❒ Headaches ❒ Shunt
- NO ❒ Peripheral nerve _____
- NN ❒ Paralysis _____
- NP ❒ Seizure Disorder _____
- NQ ❒ Sensory Condition _____
- NS ❒ Spina Bifida _____
- NT ❒ Spinal Cord Injury _____
- NU ❒ Traumatic Brain Injury/Date _____

Behavioral Health, Sleep or Other Health Conditions
- PH ❒ Sleep Disorder _____
- PI ❒ Tourette Syndrome/Type _____
- PJ ❒ Other _____
- PA/B/C ❒ Anxiety ❒ Bipolar ❒ Depression
- PF/D/E ❒ PTSD ❒ OCD ❒ ODD

Neoplasm (Cancer/Tumor)
- ❒ Please List _____

Respiratory
- RB/C/D Asthma - ❒ Mild ❒ ***Moderate** ❒ ***Severe** ❒ * ***Inhaler***
- RA ❒ Asthma - Exercise Induced
- RE ❒ Reactive Airway Disease _____
- RF ❒ Other _____

Eye and Ear
- YA ❒ Chronic Ear Infections _____
- YB ❒ Hearing Impaired ❒ Hearing Aids
- YC ❒ Ear Condition _____
- YD ❒ Visually Impaired _____
- YE ❒ Eye Condition Other _____
  ❒ Wears Glasses/Contacts

Other Health Conditions

Health Insurance ❒ *No ❒ Yes (*Insurance information may be shared with Whatcom Alliance for Healthcare Access)
Dental Insurance ❒ *No ❒ Yes

Doctor/Health Care provider		Phone		Date of last physical exam	
Specialist		Phone		Date of last exam	
Specialist		Phone		Date of last dental exam	
Dentist		Phone		Date of last vision exam	

Is medication needed at home? ❒ No ❒ Yes
Please list: _____

Is medication needed at school? ❒ No ❒ Yes
Please list: _____

If parent/guardian or authorized emergency contact cannot be reached at the time of a medical emergency, and if immediate care is urgent in the judgment of school authorities, I authorize and direct the school authorities to send the student to the hospital or doctor most accessible. I understand that I will assume full responsibility for the payment of any services rendered. I understand that the information given above will be shared with appropriate school staff that have a "need to know" in order to provide a healthy and safe environment (Family Education Rights and Privacy Act.)

Date _____ Signature _____ Relationship _____ Phone (___) _____