Clarkston SCHOOL DISTRICT
Honor the Past. Be the Future.

# 2020-2021

# Clarkston School District Health History

Student Name: _____Date of Birth: _____Healthcare Provider: _____

## Life-Threatening Medical Conditions

*Washington State Law (RCW 28A.210.320) requires 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 a Nursing Plan in place **before** attending school.*

**Does your child have a life-threatening condition?** ☐ Yes ☐ No If yes, specify condition:

**Indicate if student has been <u>diagnosed</u> by a Licensed Healthcare Provider with any of the following:**

| Health Condition | Yes | No | Explanation if "Yes" checked |
|---|---|---|---|
| Food Allergies | ☐ | ☐ | Food(s): _____<br>Describe reaction: ☐ mild ☐ moderate ☐ severe/life-threatening<br>Does your child require Antihistamine? ☐ Yes ☐ No Epinephrine? ☐ Yes ☐ No<br>Is the food(s) a sensitivity? (not a medically diagnosed allergy) ☐ Yes ☐ No<br>Signs/Symptoms of reaction: |
| Allergy to Insect Stings | ☐ | ☐ | Signs/Symptoms of reaction: _____<br>Does your child require Antihistamine? ☐ Yes ☐ No Epinephrine? ☐ Yes ☐ No |
| Medication Allergies | ☐ | ☐ | List: Reaction: |
| Other Allergies | ☐ | ☐ | List: Reaction: |
| Asthma | ☐ | ☐ | Describe severity: ☐ mild ☐ moderate ☐ severe/life-threatening<br>Asthma triggers: ☐ illness ☐ exercise ☐ allergies ☐ other _____<br>Will your child require an inhaler at school? ☐ Yes ☐ No |
| Diabetes | ☐ | ☐ | ☐ Type 1 (insulin dependent) ☐ Type 2 |
| Seizure Disorder | ☐ | ☐ | Type of seizures: Medication(s):<br>Date of last seizure: |
| Heart Condition | ☐ | ☐ | Diagnosis: |
| Cancer | ☐ | ☐ | Diagnosis: |
| Blood Disorder | ☐ | ☐ | Diagnosis: |
| ADD/ADHD | ☐ | ☐ | Medications taken: ☐ at home ☐ at school |
| Mental Health/Behavioral Issues | ☐ | ☐ | Specify:<br>Medications taken: ☐ at home ☐ at school |
| Orthopedic Condition | ☐ | ☐ | Specify: Limitations: |
| Wears Glasses | ☐ | ☐ | ☐ Distance ☐ Reading ☐ Contact Lenses |
| Hearing Loss | ☐ | ☐ | ☐ Right Ear ☐ Left Ear ☐ Hearing Aids |
| Headaches/Migraines | ☐ | ☐ | Describe: |
| Other Health Concerns | ☐ | ☐ | Describe: |

## Daily Medications:

Washington State Law (RCW 28A.210.260) requires written permission from a Licensed Healthcare Provider and Parent/Guardian before any medications **(prescription or over-the-counter)** can be given at school.

☐ Yes ☐ No Medication needed at school. Specify:_____(Authorization needed)

☐ Yes ☐ No Medication needed at home. Specify:_____

All health information is considered confidential. It may be shared with staff as needed during the time your child is enrolled in Clarkston School District in order to ensure the health and safety of your child, unless otherwise requested by you in writing.

Parent/Guardian Signature (required): _____ Date: _____

**Health Service use only:**

*Reviewed/Entered by*: _____ *Parent contacted*: _____ *Orders on file:* ☐ Yes

Revised January 2020