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**HOMEROOM** _____ ☐ **IN DISTRICT** ☐ **OUT OF DISTRICT**

**Form 336**

## South Kitsap School District No. 402

# Health History and Conditions Form

**Name**_____ **Grade** _____ **School**_____

**Date** _____ **Sex** _____ **Birth Date**_____

**Indicate below the medical conditions which are SEVERE ENOUGH TO AFFECT THE STUDENT'S SCHOOL PROGRAM OR SCHOOL PERFORMANCE.** *(Note: this information may be shared with school staff who need to know.)*

**Medical History** *(check the ones that apply to your child):*

**NB** ☐ **ADHD/ADD**

**Asthma**
**RA** ☐ Exercise Induced
**RB** ☐ Mild
**RC** ☐ Moderate
**RD** ☐ Severe

**Diabetes**
**EK** ☐ Type I
**EL** ☐ Type II
**NH** ☐ **Headaches, Migraine**
**YB** **Hearing Impaired**
☐ Hearing Problem
☐ Hearing Aids

_____

**CG** **Cardio Vascular**
☐ Other

_____

**BD** **Blood Condition**
☐ Other

_____

**UH** **Renal – Kidney/Urinary**
☐ Other

_____

**GI** **Gastro-Intstnl Cndtn**
☐ Other
_____

**YD** **Visually Impaired**
☐ Wears Glasses

**Allergies**
**EC** ☐ Environmental
**ED** ☐ Food
**EE** ☐ Insect
**EF** ☐ Latex
**EB** ☐ Other

Reacts to:
_____
_____

Describe allergic reaction:
_____
_____

**EG** **Anaphylactic Cndtn**
☐ **Epi-Pen required**

☐ **Seizures Disorder**
**NP** Date of last seizure ___/___/___
Type of seizure _____
***List any seizure medication below.***
_____
_____

**ME** ☐ Muscle or Bone Condition
_____
_____

☐ **PE Considerations/Limitations **(2)**
_____
_____

☐ **Other**
_____
_____

**NU** ☐ **Head Injury/Concussion**
_____
_____
_____

***PARENTS: *(1) Requires completion of SKSD Form #157 and 157A "Medication at School".***
*****(2) If activity is limited, Form #112 "Physical Education Activities Limitation Form" with doctor's signature is needed.***

**Is medication needed for any condition?** ☐ **Yes** ☐ **No** **Is medication needed at school?** ☐ **Yes** ☐ **No**

Name of medication, dose, and schedule: _____

Condition being treated by this medication: _____

**Medication at school (over-the-counter or prescription) requires form #157 "Medication at School".**

**List major operations, injuries, or hospitalizations. Give dates:** _____

_____

| | Medical Exam/Doctor | Eye Exam/Doctor | Dental Exam/Dentist |
|---|---|---|---|
| **Last Exam/Name** | | | |
| **Health Insurance Co.** | | | |

**In an emergency, transport to _____ hospital. Is there any health releated information or concerns that you can tell us about your son/daughter that you feel will help the school staff to better understand and work with him/her**?

_____

_____

**AUTHORIZATION FOR EMERGENCY PROCEDURE**

*If the parent(s) and health care provider named above cannot be reached at the time of an emergency, and if immediate observation or treatment is urgent in the judgment of the school authorities, I authorize and direct the school authorities to send the student to the hospital or doctor most easily accessible. I understand that I will assume full responsibility of the payment of any services rendered.*

_____ _____ _____/_____/_____

**Date** **Signature of Parent or Guardian** **Home Phone** **Cell Phone** **Work Phone**

Revised March 6, 2012