LAKE CHELAN SCHOOL DISTRICT
Educational Excellence for Everyone
Phone: 509.682.3515
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3410F

Annual Health History Update

Student Name:_____ Gender: ☐M ☐F Date of Birth:_____
Parent/Guardian Name:_____ Phone:_____ Cell:_____
Primary Doctor:_____ Phone:_____ Preferred Hospital:_____

☐ **MY STUDENT HAS NO KNOWN HEALTH CONCERNS**

SEVERE LIFE-THREATENING HEALTH CONDITIONS

If you check any of the following boxes you must contact the school nurse YEARLY to determine the need for an Emergency Care Plan. The plan must be in place and/or medication at school before starting the school year. (per RCW28A.210.320)

☐ **ANAPHYLAXIS:** Severe allergy ***with epinephrine*** prescribed (example: peanuts, tree nuts, bee stings)
Allergen(s):_____
Symptoms:_____

☐ **ASTHMA:**
What daily medications does your child use at home?_____
Does your child require an inhaler at school? ☐ Yes ☐No Asthma triggers?_____
Has your child been hospitalized or been on oral steroids within the past year? ☐ Yes ☐ No

☐ **CARDIAC:**
Heart condition:_____ Age Diagnosed:_____
Current medications:_____
Current restrictions for school:_____

☐ **DIABETES:**
☐ Type I – Insulin Dependent Age diagnosed:_____ Insulin Pump: ☐ Yes ☐ No
☐ Type II – Control with diet and oral hypoglycemic Medications:_____

☐ **SEIZURES:**
☐ Orders for emergency medication during the school day ☐ Diastat ☐ Midazolam
☐Grand Mal: Age diagnosed: _____ Medications at home: _____
☐ Petit Mal: Age diagnosed: _____ Medications at home: _____
☐ Other: _____
☐ Seizures look like: _____

☐ **OTHER LIFE-THREATENING CONDITION:**_____

Has your doctor ever diagnosed your child with any of the following (check only if it applies to your child):

☐ **Allergy: NOT life threatening, to:**_____
☐ **Digestive disorders** (food intolerances, IBS, constipation)
☐ **Neurological** (CP, Hydrocephalus, Concussions, etc.)
☐ **Orthopedic problems** (Arthritis, MS, etc.)
☐ **ADHD/ADD:** Medications:_____
☐ **Nutritional Assistance** (Tube feeding, catheterization)
☐ **Mental Health** (Depression, Anxiety, Eating disorder, OCD, etc.)
☐ **Bleeding disorders:**_____
☐ **Other respiratory concerns:**_____
☐ **Hearing Concerns:**
☐Deaf ☐Hearing loss ☐Hearing aids
☐ **Vision Concerns:**
☐Full time glasses/contacts ☐Reading glasses
☐ **Urinary/Kidney disorder** (Reflux, catheterization, etc.)
☐ **Skin Conditions:**_____

Please explain any conditions checked above: (example: allergy to eggs, vomits, no medications)

_____

Does your child need medication at school, or have any other school day health needs? ☐ Yes ☐ No
If yes, please list:_____
Does your child take daily medication at home? Please list:_____

I give permission for my child's immunization records to be updated using the Washington State Immunization System ☐ Yes ☐ No
Permission granted for emergency hospitalization or doctor's care ☐ Yes ☐No
I understand that the above information will be shared with school district personnel on a "need to know" basis.

Parent Signature: _____ Date: _____
School Nurse comments (For School Nurse Use only):_____