Edmonds SCHOOL DISTRICT
Each student learning, every day!

P-134 Att

Student Health Registration

School:____________________________Expected Start Date:___________

Student Name	Date of Birth	Gender	Grade
Parent/Guardian Name	Daytime Phone ( )	Email	
Heathcare Provider Name Phone ( )	Dentist Name Phone ( )		
Medical Insurance Information			

The following information is important for your student's health and safety. It will be forwarded to the school nurse and shared on a need to know basis to provide a safe and healthy environment at school.

ALERT: The school must know of **LIFE THREATENING** conditions (such as severe allergies, asthma, diabetes, seizures, or other at-risk conditions). This requires a Life-Threatening Emergency Care Plan and any necessary medication, supplies, and provider orders to be in place before your student can attend school (per RCW 28A. 210.320).

Does your student have a LIFE-THREATENING HEALTH CONDITION? ☐No ☐Yes: ______________________________

If your student has a LIFE THREATENING HEALTH CONDITION please fill out BOTH PAGES OF THIS FORM

STUDENT MEDICAL HISTORY

☐**ALLERGIC to:** _______________________
- ☐Mild
- ☐Moderate
- ☐Severe
- ☐**Needs Emergency med (Epi-pen, Auvi Q)**

☐**ASTHMA**
- ☐Mild
- ☐Moderate
- ☐Severe

☐**DIABETES**
- ☐Type 1
- ☐Type 2

☐**SEIZURES**
- ☐**Needs Emergency med (Diastat, Midazolam)**

☐**No Known Health Concerns**

☐ADD/ADHD
☐Alcohol/Drug use
☐Anxiety
☐Autism
☐Autoimmune Disorder
☐Blood Disorder
☐Bowel/Bladder Concerns
☐Cancer
☐Cerebral Palsy
☐Concussion Date:_______________
☐Congenital Condition
☐Cystic Fibrosis
☐Dental
☐Depression
☐Dietary Restriction
☐Ear infections
☐Eating Disorder:_________________
☐Food Intolerance:________________
☐Frequent nosebleeds

☐Headaches
☐Hearing Problems
☐Heart Condition
☐Kidney Condition
☐Mental Health Concern:
☐Menstrual Problems
☐Neurological Condition
☐Orthopedic Condition
☐Physical Disability
☐Serious Injury
☐Skin Condition:_______________
☐Social/ Emotional/Behavioral
☐Vision Problems
☐Other:________________________
☐Hospitalizations:_______________
☐Surgeries:____________________
☐Medications:__________________
____
____

If you have checked any of the above medical conditions, please explain: ______________________________
____

Is your student required to take medication/treatments during the school day?
☐NO ☐YES (requires written authorization signed by Health Care Provider)

Please explain: ____

Does your child wear: ☐glasses ☐contacts ☐hearing aids

____
Signature of Parent/Guardian Date

Please fill out next page if applicable or mark N/A and initial. rev 1/17

ALLERGIES

What causes allergic reaction? ______________________________

Date of most recent allergic reaction? ______________________________

Describe allergic reaction: ☐Hives ☐Swelling of lips, mouth, tongue, throat ☐Difficulty breathing ☐Nausea, stomach cramps, vomiting, diarrhea

Did this allergic reaction require emergency care? ☐No ☐Yes (Please explain):______________________________

Allergy medications:

NAME	DOSE	HOW OFTEN

Has your student had allergy testing completed? ☐No ☐Yes (Where & When?): ______________________________

ASTHMA

What causes asthma symptoms? ☐Respiratory Infections ☐Pollens/Molds ☐Exercise ☐Weather/temperature ☐Animals ☐Smoke ☐Poor air quality ☐Strong Odors/Perfumes

Date diagnosed with asthma:________________Health Care Provider who diagnosed student: ______________________________

Asthma medications:

NAME	DOSE	HOW OFTEN

Does your student use a spacer/aero chamber with their inhaler? ☐No ☐Yes

Has your student needed oral steroids (ie: prednisone)? ☐No ☐Yes (When): ______________________________

Has your student been to the hospital for asthma? ☐No ☐Yes (Please explain): ______________________________

DIABETES

Date when diagnosed: ________________ Medication: ☐Oral:________________☐Insulin (type): ______________________________

Equipment: ☐Insulin Pen ☐Insulin Pump (type):______________________☐CGM (type): ______________________________

Can your student check their own BG (Blood Glucose) independently? ☐No ☐Yes

Can your student count carbs independently? ☐No ☐Yes

Can your student calculate their insulin doses independently? ☐No ☐Yes

Can your student self-administer insulin independently? ☐No ☐Yes

SEIZURES

Date of first seizure: Date of most recent seizure:

Frequency of seizures occur? ☐Once ☐Daily ☐Weekly ☐Monthly ☐Yearly

Type of seizures: ______________________________

Seizure medications:

NAME	DOSE	HOW OFTEN

Has your student had a seizure that has required emergency care/medication? ☐No ☐Yes (When?): ________________

(Please explain):______________________________

Please list any other health concerns not previously listed above: N/A ☐______________________________

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Parent Initials______________________