Hood Canal
School District

HEALTH INFORMATION

Student Name _____ Birthdate _____

Teacher _____ Grade Level _____

MEDICAL HISTORY

Allergy ☐ Not Applicable

☐ Nuts ☐ Bees ☐ Food (specify _____) ☐ Seasonal ☐ Other _____

Did you seek medical attention for this allergy? ☐ Yes ☐ No

Life Threatening? ☐ Yes ☐ No Epi Pen required? ☐ Yes ☐ No

Asthma ☐ Not Applicable

Diagnosed by a physician? ☐ Yes ☐ No

Medications: ☐ Inhaler ☐ Nebulizer ☐ Other (specifiy _____)

Hospitalization for asthma? ☐ Yes ☐ No If yes, when?

Diabetic ☐ Not Applicable

Date of diagnosis: _____ Insulin dependent? ☐ Yes ☐ No

Insulin administration by: ☐ Pen ☐ Pump ☐ Syringe

Current HCP orders for students in WA state completed? ☐ Yes ☐ No

Check all that apply to your child: ☐ Glasses ☐ Contact lenses ☐ Hearing aids

Please check if you have been diagnosed by a health care provider for:

- ☐ ADD/ADHD
- ☐ Behavior concerns
- ☐ Frequent ear infections/tubes
- ☐ Eczema
- ☐ Heart condition
- ☐ Kidney disease
- ☐ Migraines
- ☐ Orthopedic conditions
- ☐ Physical disability
- ☐ Seizure disorder
- ☐ Therapy- Physical/Occupational
- ☐ Therapy – Speech/Language/Hearing
- ☐ Psychological Evaluation - Counseling
- ☐ Evaluation – Psychological/Other
- ☐ Other _____

Physician's Name: _____ Phone: (_____)_____

Address: _____ City/State/Zip: _____

Is medication needed for any condition? At home? ☐ Yes ☐ No At school? ☐ Yes ☐ No

Name of medication: _____

All medications, OTC and prescription (i.e. Tylenol, Advil, cough drops), require a doctor's order to be used at school.

EMERGENCY MEDICAL AUTHORIZATION: I understand that in the event of accident or illness, every effort will be made to contact parent/guardian. If parent/guardian cannot be reached, I authorize school authorities to obtain emergency care for my student.

_____ _____

Print Parent/Guardian Name Phone

_____ _____

Parent/Guardian Signature Date

Revised 11.24.2020 RN Reviewed: _____