HEALTH INFORMATION SURVEY

Student's Name: ____ Date of Birth: _____________________

School: ____ Grade/Teacher: _____________________

1. Please check any of the following conditions that apply to your student:

___ Asthma
___ Allergy
    ___ Bee sting ___ Food ___ Other
___ Autism/Aspergers
___ Diabetes
___ Seizures
___ Heart problem
___ Headaches

___ Vision/eye problem (e.g., glasses)
___ Hearing/ear problem
___ Head injury
___ ADD/ADHD
___ Neurological condition
___ Skin problem
___ Blood disorder

___ Birth defect/genetic disorder
___ Kidney problem
___ Eating disorder
___ Respiratory problem
___ Muscle/bone problem
___ Digestive disorder
___ Cancer
___ Other

Please explain any item checked above**:** ____

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☐ **CHECK HERE IF ANY OF THE ABOVE HEALTH CONDITIONS ARE LIFE-THREATENING.**
State law requires that medication/treatment orders and a nursing care plan be in place before student attends school (RCW 28A.210.320).

2. Has your student ever been seriously ill or injured? No____ Yes____ If yes , what was the illness or injury, when, and note whether he/she was hospitalized: ____

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3. Does your student have a physical disability? No ____ Yes ____ If yes, please describe:_________________________

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4. Does your student take medication? No ____ Yes ____
If yes, list medication(s): ____
Health condition(s) that is being treated: ____

5. Does your student have any special medical needs? No ____ Yes ____ If yes, please describe: ____________________

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I understand this information may be shared with those school staff who are supervising the student, those school staff who need the information in order to protect the health and safety of the student, and those school staff who are responsible for providing a safe learning environment.

________________________	________________________	____________
Parent/Guardian Signature	**Print Name**	**Date**

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