Grade: _____
Teacher: _____
School: _____

Walla Walla Public School District
Student Health History
To be completed by parent/guardian

Name of Student: _____Date of Birth: _____ Sex: ☐ Male ☐ Female

☐ No ☐ Yes **Glasses/Contacts**, Date of last eye evaluation: _____
☐ No ☐ Yes **Hearing aids**, Date of last hearing exam: _____

Primary Provider: Dentist: Date of last visit dental visit:

Daily Medications

State law RCW 28A.210.260 requires written permission from a Health Care Provider and parent before any medication (**prescription or over-the-counter**) can be given at school. A form is available at your school office or on Walla Walla Public Schools Health Services website.

☐ No ☐ Yes **Medication needed at school** (list):_____
☐ No ☐ Yes **Medication needed at home** (list):_____
☐ No ☐ Yes Allergies: (list)

Life Threatening Medical Conditions

Washington State law requires that students with life-threatening health conditions, where the condition would "put the child in danger of death during the school day", have medication/treatment orders and a nursing plan in place at school **before** your child can attend school. Forms are available in your school office or on Walla Walla Public Schools Health Services website.

Life Threatening Conditions (Requires Health Care Provider Orders) Please check all that apply:

☐ No ☐ Yes **Severe Allergic reaction to Nuts (list):** _____
☐ No ☐ Yes **Severe Allergic reaction to Bee Stings requiring emergency medication:** _____
☐ No ☐ Yes **Other Severe Allergies-affecting school. Specify:** _____
☐ No ☐ Yes **Severe Asthma: regularly takes medication for asthmatic condition and/or hospitalized within the last 5 years for asthmatic condition**
☐ No ☐ Yes **Diabetes**
☐ No ☐ Yes **Seizure Disorder that requires an emergency medication:** _____

Health Concerns: (which may potentially be a life threatening conditions that may require Health Care Provider orders)
Please check all that apply and explain:

☐ No ☐ Yes **Asthma: takes medication only when needed:** _____
☐ No ☐ Yes **Seizure: Type of Seizures and date of last Seizure**: _____
☐ No ☐ Yes **Heart Condition**: _____
☐ No ☐ Yes **Behavioral/Emotional Concerns**: _____
☐ No ☐ Yes **Other Health Concerns**: _____
☐ No ☐ Yes **Any Chronic or recurring illness:** _____

Does your child have any other condition that would affect his/her classroom performance or P.E. activities?
☐ No ☐Yes if yes, explain: _____

All health information is considered confidential. It will be shared electronically with staff as needed during the time your child is enrolled in Walla Walla School District in order to ensure the health and safety of your child, unless otherwise requested by you in writing.

Parent/guardian signature

_____**Date**_____