Stanwood-Camano School District **School Year 2021-2022**

Student Health Concerns

Student Name ______________________________ **Grade**______ **Birth date**__________________

Parent/Guardian Name________________________**Parent/Guardian Email**______________________________

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Medical History:

Has your student ever had a serious accident, operation, or illness? (nature and approx. date) ________________________

Please check any **HEALTHCARE PROVIDER DIAGNOSED** health concerns that your student has. If your student does not have any health concerns, simply check the box that says "No Health Concerns at this time".

☐ **No Health Concerns at this time**

ALLERGIES

☐ Bee or Insect Allergy
Reaction ☐Mild ☐ Severe/Life Threatening
Symptoms____________________________
Treatment____________________________

☐ Seasonal allergies

☐ Food allergy ☐ Food Intolerance

☐ List foods ___________________________
Reaction ☐Mild ☐ Severe/Life Threatening
Symptoms_______________________
Treatment_______________________

☐ Latex allergy

☐ Drug allergy _____________________

☐ *Has EpiPen

NEUROLOGICAL

☐ Seizure Disorder Type: _____________

☐ ADD ☐ ADHD

☐ Autism Spectrum Disorder

☐ Sensory Processing Disorder

☐ Headaches ☐ Migraines

☐ Other: _________________________

DIGESTION / ELIMINATION

☐ Bowel control problems

☐ Irritable Bowel Syndrome

☐ Bladder incontinence

☐ Other: __________________________

DIABETES

☐ Type I ☐ Type II

VISION / HEARING

☐ Vision deficit ☐ Glasses/Contacts

☐ Hearing deficit ☐ Hearing Aid

DEVELOPMENTAL

☐ Prematurity-Gestation_____________

☐ Prenatal exposure_______________________________

☐ Developmental Delay

CARDIOVASCULAR

☐ Heart Murmur ☐ Arrhythmia ______________

☐ Cardiac Disorder___________________________

☐ Heart Birth Defect

☐ Other: ____________________________________

RESPIRATORY ☐ **Current Diagnosis** ☐ **Past Diagnosis**

☐ Asthma – mild — Intermittent symptoms, infrequently uses rescue inhaler, no interference with normal activity

☐ Asthma – moderate — Persistent symptoms, uses rescue inhaler, some activity limitation

☐ Asthma – severe — Daily symptoms, uses rescue inhaler several times a day, normal activities extremely limited

Has Inhaler at? ☐ *School ☐ Home

☐ Other:___________________________________

MUSCULOSKELETAL / SKIN

☐ Cerebral Palsy

☐ Other Musculoskeletal condition______________

☐ Other Skin conditions: _______________________

BEHAVIORAL HEALTH

☐ Obsessive Compulsive Disorder

☐ Oppositional Defiant Disorder

☐ Bipolar Disorder

☐ Depression

☐ Other:___________________________________

CONGENITAL

☐ Down Syndrome

☐ Other: __________________________________

HEMATOLOGICAL

☐ Hemophiliac ☐ Sickle Cell ☐ Other:______________

Medication:

Medication student takes daily **at home** (list medications):_____________________________________

Medication **at school** (list medications):____

If medication is needed at school, complete and return an "Authorization for Medication at School" form. Health care provider AND parent/guardian signatures are required. Form can be obtained from school nurse, office, or district website.

I authorize the disclosure of health information on this form to be shared with the school nurse or other staff responsible for my student during the school day.

Parent/Guardian Signature:_________________________________ **Date:**______________________