**ANACORTES SCHOOL DISTRICT**

# STUDENT HEALTH INFORMATION

Student Name Birthdate Grade

Please check any health concern you or your doctor have noticed:
**Are any of these conditions considered "Life Threatening"? Yes ____ No ____**
**If so, please notify the school nurse for further instruction to protect your child at school.**
**MEDICAL HISTORY: PLEASE CHECK APPROPRIATE BOX. IF YES, COMMENT AND GIVE DATES.**

| NO | YES | |
|---|---|---|
| ☐ | ☐ | **ADD/ADHD (hyperactivity)** If yes, does student take medication?_____ If yes, what type?_____ |
| ☐ | ☐ | **ASTHMA** |
| ☐ | ☐ | **Allergies (bee sting / food / other)** |
| ☐ | ☐ | **DIABETES** |
| ☐ | ☐ | **SEIZURES (Epilepsy)** |
| ☐ | ☐ | Loss of consciousness / serious blows to the head |
| ☐ | ☐ | Headaches |
| ☐ | ☐ | Meningitis / Encephalitis |
| ☐ | ☐ | Nose bleeding |
| ☐ | ☐ | Sinus trouble |
| ☐ | ☐ | Recurrent ear infections (more than 2 per year) |
| ☐ | ☐ | Ear tube placement |
| ☐ | ☐ | Hearing aids / problems |
| ☐ | ☐ | Stomach aches / indigestion |
| ☐ | ☐ | Diarrhea / vomiting |
| ☐ | ☐ | Heart trouble, blood disease |
| ☐ | ☐ | Kidney disease |
| ☐ | ☐ | Chest / lung problems |
| ☐ | ☐ | Bone / Joint problems |
| ☐ | ☐ | Hospitalizations / operations |
| ☐ | ☐ | Depression / emotional health issues |
| ☐ | ☐ | Receiving ongoing medical treatment |
| ☐ | ☐ | Daily medication: Type_____ Dosage_____ When_____ (including inhalers) |
| ☐ | ☐ | Does medication need to be administered at school? |
| ☐ | | Adult supervision required during school hours:_____ Explain:_____ |

Other medical information that would be helpful for the school to know:_____
_____

Family Physician: _____ _____ _____
Name Address Phone

Family Dentist: _____ _____ _____

_____ _____
Signature of Parent/Guardian Date