CA _____
VMI _____
PPVT _____
Vision _____
Hearing _____

KENT SCHOOL DISTRICT
KENT, WASHINGTON

KINDERGARTEN
HEALTH HISTORY

1 - low risk
2 - moderate risk
3 - high risk

Today's Date _____ School _____

Name of student _____ Birthdate _____ Sex: M F

This information is needed to plan an appropriate program for your student and to prepare for any emergency situation if one should arise. Your school nurse will contact you if there are any additional questions.

BIRTH AND INFANCY - Birth weight _____ **Please explain any *yes* answers.**

Problem during pregnancy?	No ____	Yes ____	_____
Problem during labor/delivery?	No ____	Yes ____	_____
Was baby premature/overdue?	No ____	Yes ____	_____
Concerns/defect present at birth?	No ____	Yes ____	_____
Concerns during the first year?	No ____	Yes ____	_____

WAS YOUR CHILD:

Slow to walk?	No ____	Yes ____	_____
Slow to talk?	No ____	Yes ____	_____

HAS YOUR CHILD HAD:

Serious illness/injury, surgery?	No ____	Yes ____	_____

DOES YOUR CHILD HAVE

Asthma	No ____	Yes ____	_____(*If yes, complete reverse side)_____
Bee/insect allergy	No ____	Yes ____	_____
Severe allergies	No ____	Yes ____	_____(*If yes, complete reverse side)_____
Blood disorder	No ____	Yes ____	_____
Frequent ear infections	No ____	Yes ____	_____
Hearing loss	No ____	Yes ____	_____
Vision concerns	No ____	Yes ____	Wears: Glasses _____ Contacts _____ Other _____
Seizures	No ____	Yes ____	_____
Neurological condition	No ____	Yes ____	_____
ADD/ADHD (circle one/diagnosed by whom)	No ____	Yes ____	_____
Diabetes	No ____	Yes ____	_____ (*If yes, see reverse side)_____
Heart condition	No ____	Yes ____	_____
Orthopedic condition	No ____	Yes ____	_____
Toileting accidents/frequent urination	No ____	Yes ____	_____
Serious injury/surgery	No ____	Yes ____	_____
Chronic condition/disability	No ____	Yes ____	_____
Emotional health concerns	No ____	Yes ____	_____
Other health concerns	No ____	Yes ____	_____

MEDICATION

Is medication needed at home?	No ____	Yes ____	Name of medication _____
Is medication needed at school?	No ____	Yes ____	Name of medication _____

State law requires written permission from a licensed health care provider and parent before any medication, prescription or over the counter, may be taken at school. A form is available from the school office.

I understand that the information given above will be shared with appropriate school staff who need to know in order to provide for the health and safety of my student. If parents/guardian or authorized emergency contact cannot be reached at the time of a medical emergency, and if immediate care is urgent in the judgment of school authorities, I authorize and direct the school authorities to send the student to the hospital or doctor most easily accessible. I understand that I will assume full responsibility for the payment of any services rendered.

Signature _____ Relationship _____ Phone _____

- ***Please turn over for more information*** -

Anaphylaxis

If your student has an anaphylactic allergy as indicated on the reverse side of this form, please answer the following questions:

1. What is your student allergic to?_____
2. What are your student's symptoms?_____
3. Has your student been prescribed an Epi-pen?_____

Please contact the school nurse to help implement your student's individualized healthcare plan.

Diabetes

There is a state law, which requires all students with diabetes to have an individualized health care plan implemented in the school setting. If your student is diabetic, please contact the school nurse to help write your student's plan.

Asthma

If your student has asthma as indicated on the reverse side of this form, please answer the following questions:

1. How long has your child had asthma? _____ years _____ months
2. How many days would you estimate he/she missed school last year due to asthma? _____
3. How many times in the past year has your child been:

   a) Hospitalized overnight or longer for asthma? (check one) _____none _____one _____two-four _____more than four

   b) Treated in an emergency room? (check one) _____none _____one _____two-four _____more than four

   c) Treated in a Doctor's office for non-routine asthma? (check one) ____none ____one _____two-four _____more than four

4. What are your child's early warning signs of an asthma episode? (check all that apply)
   _____ cough _____ cold symptoms _____ drop in peak flow
   _____ wheezing _____ decreased exercise _____other_____
5. If your child's asthma is monitored with a peak flow meter, write in his/her best peak flow rate. _____
6. Does your child have and use a nebulizer machine at home? _____ yes _____ no
7. If your child takes medication for their asthma at home please provide the name of any medications:

_____ _____ _____

Life Threatening Conditions

RCW 28A.210.320-Children with Life-Threatening Conditions, requires a medication or treatment order as a prerequisite for children with life-threatening conditions to attend public schools. The new law defines "life-threatening condition" as a health condition that will put the child in danger of death during the school day, if a medication or treatment order and a nursing care plan are not in place. Potential life-threatening conditions include, but are not limited to, students with seizure disorders, diabetes, life-threatening allergies, and some students with asthma and heart conditions. If this law applies to your student, please contact the nurse at your child's school.

Signed: _____ Date: _____