



## 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:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Vision/eye problem     | <input type="checkbox"/> Birth defect/genetic disorder |
| <input type="checkbox"/> Allergy  | (e.g., glasses)                                 | <input type="checkbox"/> Kidney problem                |
| <input type="checkbox"/> Bee sting <input type="checkbox"/> Food <input type="checkbox"/> Other | <input type="checkbox"/> Hearing/ear problem    | <input type="checkbox"/> Eating disorder               |
| <input type="checkbox"/> Autism/Aspergers   | <input type="checkbox"/> Head injury            | <input type="checkbox"/> Respiratory problem           |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> ADD/ADHD               | <input type="checkbox"/> Muscle/bone problem           |
| <input type="checkbox"/> Seizures   | <input type="checkbox"/> Neurological condition | <input type="checkbox"/> Digestive disorder            |
| <input type="checkbox"/> Heart problem  | <input type="checkbox"/> Skin problem           | <input type="checkbox"/> Cancer                        |
| <input type="checkbox"/> Headaches  | <input type="checkbox"/> Blood disorder         | <input type="checkbox"/> Other                         |

Please explain any item checked above: \_\_\_\_\_

**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: \_\_\_\_\_

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

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: \_\_\_\_\_

**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