

	STUDENT HE	AL I H RI	ECORD					
Student Name: (Last)(Fire			Birthdate:					
	equires that students with life-threatening condition e plan completed <u>prior to the first day of school</u> . Co ms.							
Does your	student have a LIFE-THREATENING health condition	on? □ Yes	□ No					
MEDICAL HISTORY (check all that apply)								
Life-Thr REQUIRE	reatening Conditions: (Care plan is	Nervous	System					
	Ánaphylaxis (Epi-pen prescribed)		ADHD / ADD diagnosed by:					
	Allergen/s:		Autism Spectrum Disorder					
	Diabetes Type 1		Cerebral Palsy					
	Seizures – (Emergency medication required)		Developmental Disability					
	Asthma – Severe		Migraines					
	Other Life-Threatening Condition:		Headaches, Recurring					
			Seizure Disorder ☐ Current ☐ History Type:					
Congenit	al / Genetic		Traumatic Brain Injury					
	Down Syndrome		Other Neurological Condition:					
	Fetal Alcohol Spectrum Disorder							
	Please list:	Transpla	nt					
			List organ:					
	ematology							
	Anemia		r Behavioral Health					
	Hemophilia		Anxiety					
	Sickle Cell Disease Trait		Depression					
	History of Severe Nosebleeds		Sleep Disorder					
	Other Blood Condition:		Other Mental or Behavioral Health Condition					
Cardiac /	Hoart	Posnirate	ory / Breathing					
	Heart Birth Defect		Asthma – Current					
	Heart Murmur		Asthma – Ever Diagnosed					
	Other Cardiovascular Condition:		Asthma – Exercised Induced					
	Other Cardiovascular Condition.		Reactive Airway Disease					
Allerent li	mmuna Endocrina Matabalia and Nutritional		Other Respiratory Condition:					
Allergy, II	mmune, Endocrine, Metabolic and Nutritional Allergy – Food		Other Respiratory Condition.					
	Allergy – Insect	Skin						
	<del></del>	_	Fozoma or Contact Dormatitis or Pagricais					
	Allergy – Other List:		Eczema or Contact Dermatitis or Psoriasis Other Skin Condition:					
	Diabetes Type 2 Other Endestring Immune, Nutritional or Metabolics		Other Skin Condition.					
	Other Endocrine, Immune, Nutritional or Metabolic:	Donal / K	'idnov					
Castroint	estinal, Dental and Oral	Renal / K	Please list:					
	Celiac		i leade list.					
	Food Intolerance List:	Ear / Hea	rina					
	Lactose Intolerance		Chronic Ear Infections   Currently					
	Lactore intellerance		Historically					
	Encopresis		Hearing Impaired Hearing Aid/s Cochlear Implant					
	Chronic Constipation		Other Ear Condition:					
	Gastric Reflux							
	Inflammatory Bowel Disease	Eye / Vis	ion					
	Irritable Bowel Syndrome		Wears glasses / contacts					
	Other Gastrointestinal, Liver, Dental, Oral Condition		Color Vision Deficit					
	Sais. Castomicoana, Liver, Bontal, Oral Condition		Visually Impaired					
Musculoskeletal			Other Eye Condition:					
	Juvenile Rheumatoid / Idiopathic Arthritis		<b>,</b>					
	Please list:	Other He	alth Concerns:					
	<del></del>		Please list:					
Cancer /	Tumor							
☐ Please list:								
_		1						

Please initial

No known health concerns.



## STUDENT HEALTH RECORD

Student Name: (Last)	(F	irst)		Birth	ndate:	
	MEDIC	CATIONS				
	Please report all medications that you	ır student tak	es at ho	ome and/or at scho	ool.	
Is medication needed	at home? ☐ No ☐ Please list	st:				
	Yes					
la mandination mandad	ot cohool?	_1.				
Is medication needed Complete REQUIRE	_	SI:				
paperwork for medic						
school.	ation at					
	tten permission from guardian and a health	care provide	er before	e anv medication (i	prescription and over-the-	
	n at school. Forms are available from your					
annually.						
Medical Devices		Stoma				
	ve Stimulator			rostomy		
☐ Automatic	Internal Cardiac Defibrillator		Colos	stomy		
□ Pacemake	er		Trach	neostomy		
☐ Gastrosto	my tube		Urost	tomy		
☐ Jejunosto	my tube		Other	r:		
□ Brace						
☐ Prosthesis	s List:	Physical .	Activity	y / Mobility Issues	<b>;</b> :	
☐ Other med	dical devices:		_	elchair		
_			Crutcl	hes		
			Other	r List:		
<b>conditional before starting school.</b> I give permission to my child's school to add immunization information to the Immunization Information System to help the school maintain my child's school record.						
Parent/Legal Guardia	n Signature:			Date	:	
	IMMUNIZATION VER	IFICATION	(Office	e use only)		
WAIIS#					☐ Grade 7 ☐ Grade 8-12	
					Glade / Glade 6-12	
	s is COMPLETE on the WAIIS Certificate o	f Immunizatio	າກ Statu	ıs (CIS).		
OR						
☐ Immunization Status	s is CONDITIONAL on the WAIIS CIS and	the condition	al status	s expiration date is	after the first day of	
attendance.						
□ Parent/Gua	ardian has signed the conditional status ac	knowledgeme	ent on th	he CIS.		
OR						
☐ Student is not in WA	AIIS. Medically verified immunization re	cords must b	be prov	rided.		
	verified immunization records provided		-	nter statement sigr	ned	
	remied immunization records provided		ion to ei	inter statement sign	ied	
OR	(205)		14/411			
•	otion (COE) provided for all vaccines not in	compliance of	on WAII	IS CIS or in WAIIS.	•	
□ COE is full	y completed	□ Permissi	ion to er	nter statement sigr	ned	
OR						
☐ Immunization Status	s is NOT COMPLETE on the WAIIS CIS St	udent may n	ot star	t school until doc	umentation of missing	
	received that will change the CIS status	-				
	und in one ingo the old status		0. 0			
☐ Student added to So	chool Module Roster: Grade:					
Staff who varified immu	inizations:	Data:				