School: _____
Grade: _____
Riding Bus? Yes_____No_____
Today's Date: _____

2018-2019
Central Kitsap School District

CONFIDENTIAL HEALTH INFORMATION

This form must be completed each year

PLEASE COMPLETE FORM & RETURN AS SOON AS POSSIBLE

Name: _____ Birthdate: _____ M / F: _____
Last First MI

Parent Name: _____ Parent Name: _____

Street Address: _____ Street Address: _____

City: _____ Zip: _____ City: _____ Zip: _____

Phone: _____ Phone: _____

ALERT TO PARENTS: If your child has a serious medical condition, it is vital that you discuss this with your School Nurse and teacher(s) immediately. **If your student has a LIFE THREATENING condition, an Individual Health Plan created by the school nurse needs to be in place before they can start school.** In order to provide a safe and healthy environment for your child, this information will be accessible to the follow people: School Nurse, your child's teacher(s), office manager, personnel responsible for health room coverage and emergency medical personnel.

A. MEDICAL HISTORY: Check the ones that apply to your child and describe under the Comments section.

_____	ADD/ADHD	_____	Migraine Headaches	Comments:
_____	Seasonal/Environmental Allergies	_____	Headaches	
		_____	Severe Hearing problem	_____
_____	Anxiety/ Panic attack	_____	Heart Condition	_____
_____	Asthma	_____	Kidney/urinary problems	_____
_____	Bowel problem	_____	Muscular Disorder	_____
_____	Cerebral Palsy	_____	Neurological Concern	_____
_____	Diabetes	_____	Orthopedic problem	_____
_____	***Severe Allergy**	_____	Seizures	_____
_____	***Severe Allergy w/ Epi-Pen**	_____	Severe Vision problem	_____

Describe Severe Allergy:

_____

B. Other Allergies: List allergies your child has that may cause a problem at school:

Cause of the allergy: _____ Treatment: _____

Cause of the allergy: _____ Treatment: _____

C. MEDICATION: Include prescription and over-the-counter medication:

	Name	Used to treat	Taken at school?
1)	_____	_____	Yes ☐ No ☐
2)	_____	_____	Yes ☐ No ☐
3)	_____	_____	Yes ☐ No ☐

Before medication of any kind can be administered at school, an Authorization to Administer Medication form, available in the office, must be completed by parent and physician and kept on file.

D. Name of Physician: _____ Phone: _____

OFFICE: RETURN COMPLETED FORM TO NURSE