

FEDERAL WAY PUBLIC SCHOOLS

Health History

Name of Student: _____ Date: _____

Birth Date: _____ Sex: M F School: _____

Grade: _____

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.

Medical History (check all that apply)

Please explain any yes answers.

Life threatening allergy (anaphylaxis)	No	Yes	(See back)
Other allergies (specify)	No	Yes	_____
Asthma	No	Yes	_____
Diabetes	No	Yes	(See back)
Heart Condition	No	Yes	_____
Seizures	No	Yes	_____
Emotional health concerns	No	Yes	_____
Vision concerns	No	Yes	_____
Hearing concerns	No	Yes	_____
Orthopedic condition	No	Yes	_____
Serious injury, surgery, or hospitalization	No	Yes	_____
ADD/ADHD	No	Yes	_____
Bowel/Bladder concerns	No	Yes	_____
Birth Defects/Problems	No	Yes	_____
Skin conditions	No	Yes	_____
Feeding/Nutrition Concerns	No	Yes	_____
Special Equipment	No	Yes	(List) _____
Medication			
Is medication needed at home?	No	Yes	(List) _____
At school?	No	Yes	(List) _____

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.

Health History Informed Consent

The disclosure of student health information with the school is limited to the information necessary to serve the student's health or educational interest. Your signature gives permission for the school nurse to share this information with school staff on a need-to-know basis for precautions, procedures and emergency plans to protect your child at school and foster academic success. You further agree to bring to the attention of the school any *major* changes in the physical condition of your son/daughter.

X _____

Parent/Guardian Signature Phone # Date

Detailed information from Front:

Life Threatening Allergy:

Diabetes:

This form may not be used in place of form 431-A (Athletic Pre-Participation History and Physical Examination)

Physician Report - Physical Activity Recommendation (optional):

Full physical education, sports, intramural, or camp activity: Yes No

Modified or restricted activity: Yes No

Disability: Permanent Temporary Stable
 Progressive Recurrent Re-exam date

Level of activity: Sedentary Part Sedentary
 Light Moderate

Movements restricted (specify) _____

Doctor's Name _____ Phone _____ Fax _____

Doctor's Signature _____ Date _____

WAIVER STATEMENT - OPTIONAL TO PHYSICAL EXAM

I hereby give permission for _____ to participate in the regular physical education program. To the best of my knowledge he/she has no physical or mental impairments which will preclude participation and I hereby release the Federal Way Public Schools or hold them harmless for allowing my son/daughter to participate in the regular physical education program without a physical exam by a licensed physician. I do also agree to inform the school of any health problem which may arise that would preclude my child's participation.

Parent/Guardian Signature _____ Date _____

_____ Nurse Initials and Date