FEDERAL WAY PUBLIC SCHOOLS
Health History

Name of Student: _____ Date: _____

Birth Date: _____ Sex: M ☐ F ☐ School: _____

Student ID: _____ Grade: _____

Medical History (check all that apply). Please explain any "yes" answers. Your school nurse will contact you if there are any additional questions.

Severe/Life Threatening Allergy Antihistamine or EpiPen prescribed	No ☐ Yes ☐ No ☐ Yes ☐	Seizures Medications or Treatment	No ☐ Yes ☐
Asthma Mild ☐ Moderate ☐ Severe ☐ Medications or Treatment	No ☐ Yes ☐	Diabetes Medications or Treatment	No ☐ Yes ☐
Heart Condition Medications or Treatment	No ☐ Yes ☐	Other Serious Health Conditions	No ☐ Yes ☐
Emotional Health Concerns	No ☐ Yes ☐	Birth Defects/Problems	No ☐ Yes ☐
Feeding/Nutrition Concerns	No ☐ Yes ☐	Bowel/Bladder Concerns	No ☐ Yes ☐
Vision concerns	No ☐ Yes ☐	Hearing Concerns	No ☐ Yes ☐
Orthopedic Condition	No ☐ Yes ☐	Skin Conditions	No ☐ Yes ☐
Injury/Surgery/Hospitalization	No ☐ Yes ☐	ADD/ADHD	No ☐ Yes ☐
Medication at Home	No ☐ Yes ☐	Medication at School	No ☐ Yes ☐
Special Equipment	No ☐ Yes ☐	Other:	No ☐ Yes ☐

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.

Does you child have health insurance? No ☐ Yes ☐ Does your child have dental insurance? No ☐ Yes ☐

Do you want information on low-cost insurance? No ☐ Yes ☐

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

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