Willows Prep

Student Health Record

Student Name: (Last)_____ **(First)**_____ **Birthdate:**_____

State law requires that students with life-threatening conditions such as anaphylaxis, severe asthma, diabetes or seizures have a care plan completed prior to the first day of school. Contact the school as soon as possible to complete the proper forms.

Does your student have a LIFE-THREATENING health condition? ☐ **Yes** ☐ **No**

MEDICAL HISTORY (check all that apply)

Life-Threatening Conditions: (Completed form is REQUIRED)

EG ☐ **Anaphylaxis (Epi-pen prescribed)**
Allergen/s:
EK ☐ **Diabetes Type 1**
NP ☐ **Seizures – (Emergency medication required)**
RG ☐ **Asthma – Severe**
☐ **Other Life-Threatening Condition:**

Congenital / Genetic

AH ☐ Down Syndrome
AJ ☐ Fetal Alcohol Spectrum Disorder
☐ Please list:

Blood / Hematology

BA ☐ Anemia
BB ☐ Hemophilia
BC ☐ Sickle Cell Disease Trait
OJ ☐ History of Severe Nosebleeds
☐ Other Blood Condition:

Cardiac / Heart

CC ☐ Heart Birth Defect
CD ☐ Heart Murmur
☐ Other Cardiovascular Condition:

Allergy, Immune, Endocrine, Metabolic and Nutritional

ED ☐ Allergy – Food
EE ☐ Allergy – Insect
☐ Allergy – Other List:
EL ☐ Diabetes Type 2
☐ Other Endocrine, Immune, Nutritional or Metabolic:

Gastrointestinal, Dental and Oral

GA ☐ Celiac
GG ☐ Food Intolerance List:
GL ☐ Lactose Intolerance
GF ☐ Encopresis
GO ☐ Chronic Constipation
GH ☐ Gastric Reflux
GJ ☐ Inflammatory Bowel Disease
GK ☐ Irritable Bowel Syndrome
☐ Other Gastrointestinal, Liver, Dental, Oral Condition

Musculoskeletal

MC ☐ Juvenile Rheumatoid / Idiopathic Arthritis
☐ Please list:

Cancer / Tumor

☐ Please list:

Nervous System

NB ☐ ADHD / ADD diagnosed by:
NC ☐ Autism Spectrum Disorder
NE ☐ Cerebral Palsy
NF ☐ Developmental Disability
NH ☐ Migraines
NI ☐ Headaches, Recurring
NP ☐ Seizure Disorder ☐ Current ☐ History Type:
NU ☐ Traumatic Brain Injury
☐ Other Neurological Condition:

Transplant

OD ☐ List organ:

Mental or Behavioral Health

PA ☐ Anxiety
PC ☐ Depression
PH ☐ Sleep Disorder
☐ Other Mental or Behavioral Health Condition

Respiratory / Breathing

RG ☐ Asthma – Current
RH ☐ Asthma – Ever Diagnosed
RA ☐ Asthma – Exercised Induced
RE ☐ Reactive Airway Disease
☐ Other Respiratory Condition:

Skin

SB ☐ Eczema or Contact Dermatitis or Psoriasis
☐ Other Skin Condition:

Renal / Kidney

☐ Please list:

Ear / Hearing

YA ☐ Chronic Ear Infections ☐ Currently ☐ Historically
YB ☐ Hearing Impaired ☐ Hearing Aid/s Cochlear Implant
☐ Other Ear Condition:

Eye / Vision

YF ☐ Wears glasses / contacts
YE ☐ Color Vision Deficit
YD ☐ Visually Impaired
☐ Other Eye Condition:

Other Health Concerns:

☐ Please list:

OC ☐ **No known health concerns.** **Please initial** _____

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MEDICATIONS

Please report all medications that your student takes at home and/or at school.

Is medication needed at home? ☐ No ☐ Yes Please list:
Is medication needed at school? ☐ No ☐ Yes Please list: **Complete REQUIRED paperwork for medication at school.**
State law requires written permission from guardian and a health care provider before any medication (prescription and over-the-counter) may be taken at school. Forms are available from your school office or on our website and must be completed annually.

Medical Devices

- OLA ☐ Vagal Nerve Stimulator
- OLB ☐ Automatic Internal Cardiac Defibrillator
- OLC ☐ Pacemaker
- OLD ☐ Gastrostomy tube
- OLE ☐ Jejunostomy tube
- ☐ Brace
- ☐ Prosthesis List:
- ☐ Other medical devices:

Stoma

- OKA ☐ Gastrostomy
- OKB ☐ Colostomy
- OKD ☐ Tracheostomy
- OKE ☐ Urostomy
- OK ☐ Other:

Physical Activity / Mobility Issues:

- ☐ Wheelchair
- ☐ Crutches
- ☐ Other List:

I understand that the information I provided will be shared with appropriate school staff who need to know in order to provide for the health and safety of my student. If parents/guardians or authorized emergency contacts cannot be reached at the time of a medical emergency, and if immediate care is urgent in the judgement of school authorities, I authorize and direct the school authorities to send the student to the hospital or doctor most easily accessible. I understand that I will assume full responsibility for the payment of any services rendered. **I understand that Washington law requires that my student's immunizations are complete or conditional before starting school.** 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 Guardian Signature: _____ **Date:** _____

IMMUNIZATION VERIFICATION (Office use only)

WAIIS # _____ CIS Series: ☐ Preschool ☐ Grade K-6 ☐ Grade 7 ☐ Grade 8-12

☐ Immunization Status is COMPLETE on the WAIIS Certificate of Immunization Status (CIS).

OR

☐ Immunization Status is CONDITIONAL on the WAIIS CIS and the conditional status expiration date is after the first day of attendance.

☐ Parent/Guardian has signed the conditional status acknowledgement on the CIS.

OR

☐ Student is not in WAIIS. **Medically verified immunization records must be provided.**

☐ Medically verified immunization records provided ☐ Permission to enter statement signed

OR

☐ Certificate of Exemption (COE) provided for all vaccines not in compliance on WAIIS CIS or in WAIIS.

☐ COE is fully completed ☐ Permission to enter statement signed

OR

☐ Immunization Status is NOT COMPLETE on the WAIIS CIS **Student may not start school until documentation of missing immunizations is received that will change the CIS status to COMPLETE or CONDITIONAL.**

☐ Student added to School Module Roster: Grade: _____

Staff who verified immunizations: _____ Date: _____