School: ______________________

Grade: ______

Central Kitsap School District

CONFIDENTIAL HEALTH INFORMATION

This form must be completed each year if student has any of the medical conditions listed below.
Please return to the school main office or school nurse.

Name: ____ Birthdate: _____________ Today's Date: _____________
Last First MI

Parent Name: ___________________________________Address: ______________________________ Phone: _____________

Parent Name: ___________________________________ 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. It is very important to know of **LIFE THREATENING** conditions.

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
______ Anxiety/ Panic attack
______ Asthma
______ Bowel problem
______ Cerebral Palsy
______ Diabetes
______ Severe Allergy/Epi-Pen
______ Emotional Concerns
______ Headaches

______ Severe Hearing problem
______ Heart Condition
______ Kidney/urinary problems
______ Muscular Disorder
______ Neurological Concern
______ Orthopedic problem
______ Seizures
______ Severe Vision problem

______ Life Threatening Condition
Explain:
____

______ Other: ________________
(explain)
____

Comments: ____

B. ALLERGIES: List allergies your child has that cause a problem at school:

Cause of the allergy: ________________________________ Treatment: ___________________________________

Cause of the allergy: ________________________________ Treatment: ___________________________________

C. MEDICATION: Include prescription, over-the-counter and herbal 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, a Physician's Order for Medication form , available in the office, must be completed by parent and physician and kept on file.

D. Name of Physician: ________________________________ **Phone:** ____________________
Name of Dentist: ____________________________________ **Phone:** ____________________