Bellevue Student Health Registration • School Year: _________

Student's Name: ___________________________ Date of Birth: __________ Grade: ______ Gender: ______

In case a parent can't be reached, please contact the individual below. This person has agreed to assume this responsibility and is local.

Name: ______________________ Relationship: ____________ Cell#: ____________ Work#: ____________

Child's Doctor: ____________________ Phone#: ______________ Preferred Hospital: ____________________

Child's Dentist: ____________________ Phone#: ______________ Orthodontist: ______________________

Type of Health Insurance: ☐Private ☐Title 19/Medicaid ☐HawkI ☐No Health Insurance ☐Other: ____________________

HEALTH CONCERNS Mark the box ☒ if your child has a history of the following conditions. Mark additional information as needed.

Additional forms may need to be completed by your physician (marked with *). Some forms available on the school's website.

☐ **Asthma or Reactive Airway Disease**

- •Triggers ☐Exercise ☐Colds/Allergies ☐Animals ☐Smoke ☐Weather ☐Food ☐Dust/Air ☐Other: ______________
- •Will the inhaler ever be needed at school? ☐No ☐Yes➔ **Asthma Action Plan Needed***
- •Will the student carry his or her own inhaler? ☐No ☐Yes➔ **Authorization to Carry/SelfAdminister***

☐ **Diabetes** ☐Type 1 ☐Type 2

- •Does the student use insulin? ☐No ☐Yes➔ **Diabetic Medical Management Plan Needed***
- •Does the student have glucagon? ☐No ☐Yes➔ ☐At school➔ ☐Office ☐Backpack

☐**Seizure Disorder➔ Seizure Action Plan Needed***

- •Does the student have rescue meds? ☐No ☐Yes➔ ☐At school➔ ☐Office ☐Backpack

☐**Allergies** (Food, Insect, Seasonal, Medication)

- •Is the student at risk for anaphylaxis at school? ☐No ☐Yes➔ **Allergy & Anaphylaxis Emergency Plan Needed***
- •Will the student need a lunch accommodations? ☐No ☐Yes➔ **Diet Modification Form Needed***
- •Does the student have an EpiPen? ☐No ☐Yes➔ ☐At school➔ ☐Office ☐Backpack
- •List allergies below:
  - ☐Food(s)➔ ☐Peanut ☐Tree Nut ☐Eggs ☐Milk ☐Fish ☐Shellfish ☐Wheat ☐Soy ☐Gluten ☐Other: ____________
  - ☐Insect stings ☐Seasonal allergies ☐Medication(s): ____________________ ☐Other: ______________

☐Heart Condition/Murmur/Disease/Surgery: ______________________________________

☐Activity Restrictions (ongoing)➔ **Doctor's note required for explanation***: ____________________________

☐ADD/ADHD ☐Emotional and/or Behavioral Diagnoses➔ ☐Anxiety ☐Depression ☐Other: ____________________

☐Requires medication (list in chart below)

☐Headaches/Migraines ☐Requires medication (list in chart below)

☐Bowel/Bladder Concerns or Incontinence:

☐Assistive Equipment➔ ☐Glasses/Contacts ☐Hearing Aids ☐Wheelchair ☐Other: ____________________

☐History of Concussion / Head Injury: ______________________________________

☐Other medical history or current medical/developmental concerns that could affect child's education *(use back if necessary):* ________

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MEDICATIONS- List ALL medications taken regularly at home or at school. Please specify frequency and reason for use.

Medication:	Dose:	Time(s) Taken:	Frequency:	School/Home	Reason for use:

*I understand that any medication sent from home to be taken at school needs to be in the original labeled container and **a Medication Authorization Form** must be completed in order for it to be given. I understand that students* may *NOT carry any medications. I give permission to the school to contact my child's doctor to authorize medications/plans of care as necessary. I understand it is my responsibility to update any of the above information as needed. I understand this information is confidential but may be shared with appropriate school personnel when necessary for the child's safety or education.*

Parent/Guardian Signature: ______________________________________ Date: ______________