Ferndale School District

Health Inventory (for school records)

To be completed by parent/guardian

Student Name
(Last, First Middle) ________________________________ DOB ______________ M ☐ F ☐ Grade _____ ID#_____________

Does your child have a "Life-Threatening" Health Condition? (Code OB) ☐No ☐Yes
Washington State Law requires that Life Threatening conditions such as anaphylaxis, severe asthma or insulin dependent diabetes; must have doctor's orders, medication, an Individual Health Plan (IHP), and staff training, completed prior to the student's first day of attendance.

This information will replace and/or update any previously provided health information.
I understand the information given below will be shared with appropriate school staff to provide a healthy and safe environment for my child (Family Education Rights and Privacy Act).

Please check each box that applies and sign below.

☐ **No Health Conditions** that impact learning or need accommodations at this time.

☐ **Food Allergy to** (ED)____________________________
☐ Life Threatening ☐ Mild reaction
☐ Food Intolerance (lactose, gluten, other) (GG)

☐ **Insect Allergy to** (EE)____________________________
☐ Life Threatening ☐ Mild reaction

☐ **Drug Allergy**, specify (EM)________________________

☐ **Environmental/Seasonal Allergy**, specify (E_)__________

Respiratory/Asthma (R_)
☐ Mild Asthma (inhaler will **not** be needed at school and/or athletics)
☐ Moderate Asthma (inhaler **will** be needed at school and/or athletics)
Triggers ____

Gastrointestinal Condition
☐ Celiac Disease (GA) ☐ Encopresis/Soiling (GF)
☐ Irritable Bowel (GK) ☐ GERD (GH)
☐ Inflammatory Bowel, specify (G_)____________________

Mental Health Diagnosis
☐ Anxiety (PA) ☐ Depression (PC) ☐ Bipolar (PB)
☐ ODD (PE) ☐ PTSD (PF) ☐ OCD (PD)
☐ Other_______

☐ **ADHD/ADD** (NB)
☐ Diagnosed by_____________________________________

☐ **Seizure Disorder**, specify (NP)___________________

☐ **Immunocompromised** (EQ)___________________

Other Conditions
☐ Autism Spectrum Disorder (NC)
☐ Blood Disorder, specify (B_)_______________
☐ Cerebral Palsy (NE)
☐ Cancer, specify (T_)______________________
☐ Congenital Condition, specify (A_)___________
☐ Contact Dermatitis, Eczema (SB)
☐ Diabetes Type 1 (EK)
☐ Diabetes Type 2 (EL)
☐ Endocrine, specify (E_)____________________
☐ Heart Condition, specify (C_)________________
☐ Headaches, recurring (NI)
☐ Migraine headache (NH)
☐ Hydrocephalus/Shunt (NJ)
☐ Juvenile Rheumatoid Arthritis (MC)
☐ Tourette's Syndrome (PI)
☐ Urinary Condition, specify (U_)______________

☐ Glasses/Contacts (Vision, CG)
☐ Ear/Eye condition (Y_)_____________________

Other Health Conditions_______________________

____

Health/Physical Accommodations_________________

____

Does your child have Health Insurance? ☐No ☐Yes
Physician/Health Care Provider

Does your child have dental insurance? ☐No ☐Yes
Dentist

Is medication needed at school? ☐No ☐Yes, and I understand an authorization form needs to be completed **each school year**.
Please list medications

If my child has a medical emergency, I give consent for Ferndale School District to call the emergency medical system (911) or seek emergency medical care. I understand school personnel will contact me as soon as it is feasible. I understand that I will assume full responsibility for the payment of any services rendered.

Signature **Relationship** **Date** **Phone ( )**