STUDENT HEALTH INFORMATION

Information on this form is to be filled out (updated) for each new school year. Please complete this form and return to your school as soon as possible.

Name: ______________________ School Year: ______________

School: ______________ Grade: __________ Birthdate: __________

SPECIAL HEALTH CARE PLANNING

- ☐ **Diabetes** (EK) **Date of diagnosis:** ________ **My child has:** ☐ insulin pump ☐ insulin pen ☐ insulin vial/syringe
- ☐ **Seizure Disorder** (NP) My child needs **emergency** medication for seizures. *Name of medication: ________
- ☐ **Special Health Care Planning** – My child has special health care needs such as – tube feedings, breathing tube, catheter, intravenous tubes or other. Treatment order **required**.
  Please describe your child's condition(s): ______________
- ☐ **Mobility Aids –** My child requires special mobility aids such as a wheelchair, walker.__________

LIFE THREATENING CONDITIONS

If mild or moderate asthma or allergies, see box below, "Health Conditions"

- ☐ **Life threatening** (OB) condition requiring *epinephrine auto injector ☐ Allergy ☐ Asthma
  Allergen(s): ______________
- ☐ **Other** life threatening condition: ______________

ALERT TO PARENTS/GUARDIANS: The nurse **must** know of **LIFE THREATENING** conditions (for example severe allergy with anaphylaxis, diabetes, severe asthma) **prior to the start of school**, as these require an Individualized Health Plan (per RCW 28A.210.320). Contact your school to begin the process for a student health care plan and/or medications at school.

HEALTH CONDITIONS

Check any of these conditions which your child has or has had:

- ☐ ADD/ADHD (NB)
- ☐ Allergies (E_) mild or moderate (circle one)
- ☐ Asthma mild (RB) inhaler **not** needed at school
- ☐ Asthma moderate (RC) inhaler **needed** at school
- ☐ Blood Disorder (B_)
- ☐ Cancer (T_)
- ☐ Developmental Condition
- ☐ Hearing or Vision (Y_)
- ☐ Heart Problems (C_)
- ☐ Mental Health (P_)
- ☐ Neuro/Brain Injury (N_)
- ☐ Muscle/Bones (M_)
- ☐ Other

If you have checked any of the above medical conditions/concerns, please explain: ______________

____

____

*Medication requires Authorization for Medications at School form and medication prior to attending school.

AUTHORIZATION FOR EMERGENCY PROCEDURE

If the parent/guardian and Licensed Health Care Provider named on the registration record cannot be reached at the time of an emergency and if immediate observation or treatment is urgent in the judgment of the school authorities, I authorize and direct the school authorities to send my child (properly accompanied) to the hospital or Licensed Health Care Provider most easily accessible. I understand that I will assume full responsibility for the payment of any service rendered.

The above checked health conditions may be shared with school personnel on a "need to know" basis.

Parent/Guardian Name: ______________ **Date:** ________ **Phone Number:** __________

Please Print