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: _____

HEALTH CONDITIONS

Check if these apply to your child:

- ☐ ADD/ADHD (N_): Diagnosed by_____
- ☐ Non-Life Threatening Allergies (E_):
  List: _____
- ☐ Asthma (R_): Medication at school? Yes/No
- ☐ Autism Spectrum Disorder (NC):
  Diagnosed by: _____
- ☐ Developmental Condition (NF): List_____
- ☐ Heart Condition (C_): List_____
- ☐ Mental Health Condition (P_): List_____
  _____
- ☐ Neuro/Brain injury (N_): List _____
- ☐ Muscle/Bone (M_): List _____
- ☐ Hearing or Vision Impairment (Y_): List _____
- ☐ Other: Describe concerns_____
  _____

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

- ☐ **Life threatening** (OB) condition ☐ Anaphylactic Allergy (epipen required) ☐ Critical Asthma (epipen required)
  Allergen(s): _____
- ☐ **Other** Life Threatening condition: _____

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

ALERT TO PARENTS/GUARDIANS: If your child has a **Life Threatening** health condition (for example, severe allergy with anaphylaxis, diabetes, severe asthma) you must meet/speak with the School Nurse **prior** to your child starting school. These conditions 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.

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