Mercer Island School District

Student Health Form (Confidential)

Student Name: _____ **Date of Birth:** _____ **Male:** _____ **Female:** _____

School: _____ **Grade:** _____ **Class of:** _____

LIFE THREATENING Medical Conditions (Check all that apply):

If your child has a life threatening medical condition, state law requires a medication/treatment order from a Health Care Provider, and a school nurse Health Care Plan before your child can attend school. The MISD medication form and school nurse contact information is available on the Health Services website: *www.mercerislandschools.org/healthservices*

Does your child have any of the following conditions? Please explain:

No ___ Yes___ **Severe** allergic reaction **(requiring epinephrine auto injector)** to tree nuts, peanuts _____

No ___ Yes___ **Severe** allergic reaction **(requiring epinephrine auto injector)** to other foods _____

No ___ Yes___ **Severe** allergic reaction **(requiring epinephrine auto injector)** to bee stings, other insects: _____

No ___ Yes___ Other **severe** allergies **(requiring epinephrine auto injector)** - affecting school. Specify: _____

No ___ Yes___ Severe asthma that requires emergency medication kept at school: _____

No ___ Yes___ Seizure disorder that requires emergency medication or device kept at school: _____

No ___ Yes___ Diabetes: _____

No ___ Yes___ Heart condition: _____

Other Medical Conditions (If epinephrine auto injector is required, see LIFE THREATENING Medical conditions above). Does your child have any of the following OTHER conditions that would affect his/her classroom performance or P.E. activities? (Check all that apply):

Please explain:

No ___ Yes___ Mild Allergies. Specify: _____

No ___ Yes___ Asthma: Students self-carrying inhalers **must have a Medication Authorization Form on file** in the health room.

No ___ Yes___ History of seizure disorder: _____ Type and date of last seizure: _____

No ___ Yes___ History of heart condition: _____

No ___ Yes___ Digestive, bowel or bladder problems: _____

No ___ Yes___ Growth problems: _____

No ___ Yes___ Skeletal limitations: _____

No ___ Yes___ Cancer/Leukemia: _____

No ___ Yes___ Neuromuscular problems: _____

No ___ Yes___ Other developmental disability: _____

No ___ Yes___ Attention Deficit Disorder: _____

No ___ Yes___ Behavioral/Emotional concerns: _____

No ___ Yes___ Tourette's Syndrome: _____

No ___ Yes___ Migraine headaches: _____

No ___ Yes___ PE considerations: _____

No ___ Yes___ Vision deficit: _____

No ___ Yes___ Hearing loss: _____

No ___ Yes___ Routine medication: _____

No ___ Yes___ Other (please explain): _____

Medications: State law requires written permission from a Health Care Provider and parent before any medication (prescription or over-the-counter) can be given or carried by student at school. A form is available from the school nurse or MISD Health Services website: *www.mercerislandschools.org/healthservices* (under Health Information and Forms).

This information is considered confidential. It will be shared with school staff on a need-to-know basis. I understand 911 may be called to assist in a medical emergency during school hours. I understand it is my responsibility to notify the school office in writing if there are any changes in my child's health.

Preferred Doctor: _____ Phone number: _____

Preferred Dentist: _____ Phone number: _____

Preferred Hospital: _____ Phone number: _____

Parent/Guardian Signature: _____ **Date:** _____