STUDENT HEALTH INFORMATION

Information on this form is to be updated 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.

I understand that the information I provided will be shared with the appropriate school staff who need to know in order to provide for the health and safety of my child. If the parents/guardians and authorized emergency contacts cannot be reached at the time of a medical emergency, and if immediate care is urgent in the judgment of the school authorities, I authorize and direct the school authorities to send my child to the hospital or Health Care Provider most easily accessible. I understand that I will assume full responsibility for the payment of any services rendered.

Parent/Guardian Name:______________________________**Phone Number:**______________________
Please Print

I understand that Washington law requires that my student's immunizations are complete or conditional before starting school. I give permission to my child's school to add verified immunization information to the Washington State Immunization Information System (WAIIS) to help the school maintain my child's school record.

Parent/Guardian Signature:____ **Date**:______________