Confidential Emergency Health Information

Name: _____ DOB: _____

School: _____ Grade: _____

ALERT TO PARENTS/GUARDIANS: If your child has a **life-threatening health condition** (i.e. severe allergy requiring an Epi-pen, severe asthma, insulin-dependent diabetes, severe seizures etc.), Washington State Law SHB 2834 **requires** that a medication or treatment order and a Health Care Plan be in place **before** your child's first day of school each year. Please contact your School Nurse for more information

In order to provide a safe and healthy environment for your child, this information will be accessible to the following people: Principal, nurse, your student's teachers, office professionals, personnel responsible for health room coverage, and medical emergency personnel.

HEALTH CONDTIONS: For each condition listed below:

Check each box for the conditions that currently apply to your child, and describe in the comment field.

- ☐ **Allergy requiring Epi-pen**
- ☐ **Insulin-dependent Diabetes**
- ☐ **Asthma**
- ☐ **Seizures**
- ☐ **Other Life-threatening Health condition**
- ☐ Medication Allergy
- ☐ Food Allergy/Sensitivity (not life threatening)
- ☐ Environmental Allergy
- ☐ Bleeding Disorder
- ☐ Neurological Condition
- ☐ Depression
- ☐ Anxiety
- ☐ Mental Health Condition
- ☐ Digestive Condition
- ☐ Chronic Headaches/Migraines
- ☐ Heart Condition
- ☐ Orthopedic Condition
- ☐ Hearing Condition
- ☐ Eye/Ophthalmic Condition
- ☐ ADHD
- ☐ Autism
- ☐ Endocrine Condition
- ☐ Sleep Disorder
- ☐ Immunocompromised
- ☐ Other condition- please describe below

If yes to any above, describe:

_____

_____

MEDICATIONS:

Does your child take any **medication at home**? If yes, list below.

Name of Medication	Used to Treat	How often

Does your child need to take any **medication at school**? If yes, list below.

Name of Medication	Used to Treat	How often

Before medication can be administered at school, a Medication Administration Form must be completed by both parent and licensed provider and kept on file at school.

Elementary/Middle School Form: 3416F1 - Authorization for Administration of Medication at Elementary and Middle School - Issaquah School District 411 (isd411.org)

High School Form: 3416F2 - Authorization for Administration of Medication at High School - Issaquah School District 411 (isd411.org)

HOSPITALIZATIONS

Please list any hospitalizations, operations, or significant injuries in the past 3 years:

_____

_____

ASSISTIVE DEVICES: Check all assistive devices that your student uses and will use at school.

☐ Glasses	☐ Hearing Aid(s)	☐ Wheelchair; Stroller
☐ Contacts	☐ Cochlear Implant	☐Other Device (describe)

_____

_____

EMERGENCY INFORMATION

Parents/Guardians: *List phone numbers in order of preference*

	Parent/Guardian 1	Parent/Guardian 2
Name		
Phone #s		
Address		
E-mail		

Emergency Contact(s): *List phone numbers in order of preference*

	Contact 1	Contact 2
Name		
Phone #s		
Relationship		

If parent/guardian cannot be reached at the time of an emergency, and observation or treatment is deemed necessary by school authorities, I authorize and direct the school authorities to send the student (properly accompanied) to the closest emergency department. In the event that a choice of emergencies departments is an option, the preferred hospital is:_____

Parent/Guardian Signature _____ Date signed _____