	Ferndale School District 6041 Vista Dr • Ferndale, WA 98248 (360) 383-9200• http://ferndalesd.org

STUDENT HEALTH INFORMATION
School Year: 2023 - 2024

Student Name	Student's Name	**Grade**	Student's Grade
School	Student's School Desc	**Birth Date**	Student's DOB

Information on this form is to be filled out (updated) for each new school year.

HEALTH CONDITIONS

Check if these apply to your child:

☐ ADD/ADHD (N_): Diagnosed by: ADD Diagnosed By:	☐ Heart Condition (C_): List: HC List
☐ Non-Life Threatening Allergies (E__): List: Non LT List	☐ Mental Health Condition (P_): List: MH List
☐ Asthma (R_): Medication at School? A Y/N	☐ Neuro/Brain Injury (N_): List: NBI List
☐ Autism Spectrum Disorder (NC): Diagnosed by: Aut Diag	☐ Muscle/Bone (M_): List: MB List
☐ Developmental Condition (NF): List: DC List	☐ Hearing or Vision Impairment (Y_): List: HVI List
☐ Other: Describe Concerns: Other List	

SPECIAL HEALTH CARE PLANNING

☐ **Diabetes** (EK) **Date of diagnosis:** Diab Date **My child has:** ☐ insulin pump ☐ insulin pen ☐ insulin vial/syringe
☐ **Seizure Disorder** (NP) My child needs **emergency** medication for seizures.*Name of medication: Seizure Med
☐ **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: Spec HC Plan Desc
☐ **Mobility Aids** - My child requires special mobility aids such as a wheelchair, walker. List:Mobility Aids List

LIFE THREATENING CONDITIONS

☐ **Life Threatening** (OB) Anaphylactic Allergy (epinephrine required) Critical Asthma (epinephrine required) Allergen(s)/Trigger(s): Life Threat Trig
☐ **Other** Life Threatening condition: Other LT Cond List

*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 PROCEDURES

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

Parent/Guardian Name	Family 1 Guardian 1 Name	**Phone Number**	Family 1 Phone
Parent/Guardian Electronic Sign	Par/Guard Electrnc Sign	**Date**	Date Parent/Guard Sign

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 Electronic Signature: Guard Elect Sign WAIIS **Date:** Date Guard. Sign WAIIS