Mansfield School District
PO Box 188, Mansfield, WA 98830-0188
Phone: 509-683-1012
FAX: 509-683-1281

STUDENT HEALTH INFORMATION

The information below is to help school staff understand any health concerns that might affect your child's safety or learning

Student's Name:_____ _____ _____
First Middle Last

Date of Brith:_____ Sex:_____ Grade:_____

Parent/Guardian name(s):_____

Daytime phone: #`1_____ #2_____ #3_____

MEDICAL HISTORY *Please mark if you child has any of the following health conditions:*

☐ My child has **NO HEALTH PROBLEMS**

_____ Asthma ☐ Will need inhaler at school ☐ Seen in hospital/Emergency Room in last five years for asthma

_____ Severe allergy requiring Epi-pen? Allergy to : ☐ Food ☐ Bees/Insects ☐ Plants ☐ Animals ☐ Drugs

_____ Diabetes ☐ requires insulin injection

_____ Seizure disorder

_____ Heart Condition

_____ Frequent or severe headache

_____ Behavior or emotional concerns

_____ ADD/ADHD

_____ **Other – please explain any health concerns you think we should know about at school:**

Does your child wear hearing aids? ☐ Yes ☐ No Does your child wear glasses/contacts? ☐ Yes ☐ No

Do any of the above condition(s) limit/affect your child at school? ☐ No ☐ Yes, explain:

LIFE-THREATENING CONDITIONS

Does your child have a life-threatening health condition? ☐ No ☐ Yes* Describe:

If yes, a meeting with the school nurse is required. Washington State Law requires that medication or treatment orders and a health care plan be in place prior to starting school.

MEDICATION

Does your child take any medications? ☐ No ☐ Yes, name medication:

Reason for taking medication:

Will medication be needed at school, please contact the school for the "Medication Authorization" form. **This form must be completed every year before any medication may be administered at school.**

MEDICAL

Does your child have a health care provider? ☐ Yes ☐ No

Name of child's health care provider_____ Phone number_____

DENTAL

Does your child have a dentist? ☐ Yes ☐ No

Name of child's dentist_____ Phone number_____

INSURANCE

Does your child have medical insurance coverage? ☐ Yes ☐ No ☐ Don't know

Does your child have dental insurance coverage? ☐ Yes ☐ No ☐ Don't know

Would you like assistance finding insurance for your child? ☐ Yes

AUTHORIZATION FOR SHARING HEALTH INFORMATION I understand that the information give above may be shared with some school staff to provide for the health and safety of my child.

Parent/Guardian Signature_____ Date_____

RN initials_____ Date_____