NEWMARKET SKILLS CENTER

Reviewed by: _____ Date: _____

ANNUAL EMERGENCY AND STUDENT HEALTH INFORMATION 2024-2025

Student Name | Birthdate | Gender | Grade | Teacher

Parent/Guardian Name | Address | City | Zip Code | Cell/Home # | Work # | Email

Parent/Guardian Name | Address | City | Zip Code | Cell/Home # | Work # | Email

Health Care Provider | Phone | Preferred Hospital | Dental Care Provider | Phone

Type of Medical Insurance (circle one) Private Military/Tricare Apple Health/Medicaid None Other: _____

In an emergency and unable to reach parent/guardian, please contact:

Emergency Contact Name | Address | City | Zip Code | Cell/Home # | Work # | Email

Life–Threatening Conditions

RCW 28.A210.320 requires every public school to prohibit attendance at school for any and all purposes for any student with a "Life-Threatening Condition" who does not have medication or treatment orders and a nursing care plan on file at the school. A "Life-Threatening Condition" is defined as a health condition that will put the child in danger of death during the school day if medication or treatment orders and a nursing care plan are not in place. Students who are not in compliance with RCW 28A.210.320 are prohibited from attendance until such time that they come into complete compliance. Any parent/legal guardian who contests the school's decision has the right to due process procedures as found in Tumwater School District Policy 3200.

Does your child have a life-threatening condition? ☐Yes ☐No

Epi-Pen prescribed ☐Yes ☐No Allergic to: _____

Describe reaction: _____

Date of last reaction: _____

Does your child have severe asthma? ☐Yes ☐No
i.e. ER visit/Hospital Stay/Oral Steroids/2 unplanned visits for asthma in the last year?

☐ Diabetes Type 1 ☐ Bleeding Condition: Describe _____

☐ Seizures: ☐ Current ☐ History Type _____

☐ Cardiac: Describe _____

Health Information

☐ **No Medical Conditions**

☐ Allergies: Please list _____

Describe mild reaction _____

☐ Asthma Triggers: ☐Resp. Infection ☐Exercise ☐Pollen ☐Molds ☐Smoke

☐Strong odors/fumes ☐Weather/Temp Change ☐Food _____

☐ADD/ADHD Dx by/year _____ ☐ASD Dx by/ year _____

☐Speech Condition ☐Glasses/Contacts ☐Hearing Aid(s)

☐Feeding Support _____ ☐Mobility Support _____

☐Other Health Conditions _____

_____

Medication(s)Currently Used: Taken at:

_____ ☐School ☐Home

_____ ☐School ☐Home

_____ ☐School ☐Home

District Policy for Administering Medication to Students: Medications, prescriptive or over the counter, may be administered to students by building administrators or their designee(s) only with **WRITTEN PERMISSION of the parent/guardian AND a Licensed Health Care Provider's Order for Medication at School**. I understand that licensed healthcare providers have Authorization for Medication forms or the form is available at TSD schools or online at the TSD website.

If your child is ill/injured at school, we will contact the parent/legal guardian or emergency contact person, if at all possible, and call 911, if the injury or illness warrants it. I consent to the release of medical information related to my child, to school personnel, as needed, to ensure his/her safety at school. I understand that it will be my responsibility to arrange for payment for medical care, should my child be ill/injured. I give permission to my child's school to add immunization information to the Immunization Information System to help maintain my child's records and for the release of information.

I have read and understand this form. _____ _____
Parent/Guardian Signature Date

Updated 10-01-24