GRAND COULEE DAM SCHOOL DISTRICT - Student Health/Athletic Information Form

Student Name_____ **Date of Birth:** _____ **Grade:**_____

☐ **Male** ☐ **Female**

Please place an X on all health conditions which apply to your student.

☐ My child has no known health problems

☐ Asthma - Use inhaler at school? Yes☐ No ☐ If answer is **Yes**, additional signed forms are required

☐ Bee Sting Allergy - Treat with: Benadryl ☐ Epi-pen ☐ Other ☐ :_____
If medication is needed, additional signed forms are required

☐ Food Allergy:_____Treat with: Benadryl ☐ Epi-Pen ☐ Other ☐ :_____
If medication is needed, additional signed forms are required

☐ Other Allergies: _____

☐ Diabetes: _____

☐ Heart Condition - Activity Restrictions? Yes ☐ No ☐ _____

☐ Seizures - Uses seizure medication? Yes ☐ No ☐ _____

☐ Known Hearing Loss: _____

☐ Physical or birth defect: _____

☐ Head injury or Concussion (date and information): _____

☐ Other: _____

Medications used at home: _____

Are any of the above conditions life threatening? Yes ☐ No ☐

As Parent/Guardian, I agree to contact the school nurse to create an Individualized Health Care/504 Plan for my child with a life threatening condition. State law requires all students with life threatening conditions to have both medical authorization and necessary medication at school before the student will be allowed to attend school. Medication that may be required under the law include, but are not limited to: meter-dose inhalers, Epi-Pens, insulin, and medication for seizures (per RCW28A.210Sec.1).
Consent: I authorize and give my consent to the authorities of Grand Coulee Dam School District to obtain emergency medical treatment. I also authorize medical authorities to perform upon or administer necessary emergency medical or surgical treatment to the above named student. District authorities are not excused from attempting to contact me before relying upon this authorization. I also authorize that the information listed above may be shared with school personnel on a need-to-know basis to facilitate the school district in providing a safe environment for my child. I authorize the 504 coordinator to evaluate my student for a 504 accommodation plan if needed. **If there are any health changes to the above listed information, it will be the parent/guardian's responsibility to inform the school on the yearly update student information form.**

Parent/Guardian Name (PLEASE PRINT):_____

Signature of Parent/Guardian: _____ Date: _____

Home Phone: _____Work Phone: _____ Cell:_____

Emergency Contact: _____ Phone: _____ Cell:_____

Provider Name: _____ Provider Phone:_____