LONGVIEW PUBLIC SCHOOLS
CREATING THE FUTURE TODAY

SCHOOL STUDENT HEALTH INFORMATION ANNUAL UPDATE

We use this updated information to assist in caring for your student at school. Please *carefully* complete **BOTH SIDES** of this form and return to the school Health Office as soon as possible.

In order to provide a safe and healthy environment for your child, this confidential information will be accessible to: School Health Personnel, your child's teachers and care givers, and emergency medical personnel.

Name: _____ Birthdate: _____ Sex: M ☐ F ☐

School: _____ Grade: _____ Today's Date: _____

PARENTS/GUARDIANS: If your child has a serious medical condition, it is vital that you discuss this with your Health Office Immediately. **We MUST be alerted to LIFE THREATENING HEALTH CONDITIONS prior to the start of school.** These conditions may require an Emergency Care Plan with Emergency Medications (per RCW28A.210.320). **If an emergency medication or plan is needed, and the proper paperwork is not in place, we are required to EXCLUDE the child from school.**

LIFE THREATENING HEALTH CONDITIONS: If you check any of these boxes, you must contact the School Health Room.

☐ **Asthma * Severe *** – please answer the following questions

Yes ☐ **No** ☐ Does this child use rescue inhaler routinely for asthma symptoms?
Daily ☐ Weekly ☐ Monthly ☐ (ie: Atrovent, ProAir, Ventolin)

Yes ☐ **No** ☐ Has your child used steroids for asthma symptoms in the past year?
☐ inhaled steroids (ie: Flovent or Qvar) or ☐ Prednisone

Yes ☐ **No** ☐ Has your child been hospitalized for asthma in the past year?

☐ **Allergy/Anaphylaxis – *SEVERE, WITH AN EPINEPHRINE PRESCRIPTION (EPI-PEN)***
Cause of allergy (Bee sting, Peanut/Nut, Food, Medication, Other):_____
Describe previous reaction:_____

☐ **Diabetes, Type 1**
Date of Diagnosis:_____ ☐ Uses a pump ☐ If so, for how many years in use? _____

☐ **Seizure Disorder**
☐ Is currently taking seizure medication

☐ **Other potentially life threatening issues:** _____

☐ **My child has no potentially life threatening health conditions.**

- Allergy, ***not*** life threatening:

Allergen: _____ Reaction: _____
Allergen: _____ Reaction: _____

- History of Concussion / Head Injury:

Date of Injury: _____ Was a Health Care Provider Seen? _____
Date of Injury: _____ Was a Health Care Provider Seen? _____

- Hearing Concerns? ☐ Has a known hearing loss ☐ Wears hearing aids?
- Vision Concerns? ☐ Glasses ☐ Contacts
- Other Concerns (Please contact the school health office): _____

☐ **My child has none of the conditions listed above.**

HEALTH HISTORY: Please check the health conditions that apply to your child

Health Condition*:**	**Yes**	**No**	**Explain:**
Brain or Spinal Disorder			
Cerebral Palsy			
Migraine Headaches			
ADD/ADHD / Hyperactivity			
Mental Health Behavioral Issues, or depression, anxiety			
Heart / Cardiovascular Disease			
Blood / bleeding disorder			
Breathing Issues (including **Asthma** – Mild-Moderate)			
Digestive / Stomach Issues			
Bowel or Bladder Issues			
Bladder Issues			
Cancer			
Other:			

Washington school immunization law RCW 28A.210.120 requires that you must provide medically verified immunization records for your child by the first day of school.

Would you like the school nurse to obtain these records from the Washington State Immunization Information System (WA IIS)? Yes ☐ No ☐

MEDICATIONS:

Does your child take medication at home? ☐ Yes ☐ No

Please list here:

Does your child need to take medication AT SCHOOL? ☐ YES*** ☐ No

**** IF YES YOU MUST CONTACT THE SCHOOL HEALTH PERSONNEL and complete necessary paperwork.** IF medications are needed during the school day; RCW 28A.210.206 requires a written authorization form for medication to be administered at school, **to be signed by the parent/guardian *AND* a health care provider**.

Ask your school for these forms, or download them from the district website.

*includes over the counter, prescription, herbal, and naturopathic medications.**

Doctor's Name: _____

PARENT/GUARDIAN PRINTED NAME: _____ **Date:** _____

PARENT/GUARDIAN SIGNATURE: _____ **Phone Number:** _____

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*****Please provide documentation of your child's condition from your medical provider.**

*The information on this form may be shared confidentially with school staff and emergency responders as needed. In the event of a medical emergency with my student, I understand every effort will be made to inform me. If emergency care is needed, I authorize qualified professionals to provide assessment, diagnosis, and any necessary emergency treatment. I understand that the school district assumes no financial liability for expenses incurred due to accident, injury, and/or unforeseen circumstances**. I understand that Washington law requires that my student's immunizations are complete or conditional before starting school. I give permission to my student's school to add immunizations into the Washington State Immunization Information System to maintain my student's immunization record.***

By completing and signing this form, you as the parent/guardian agree that you will be responsible for communicating ANY changes to this form with the school office and health specialist.