



Reviewed by: _____ Date: _____

ANNUAL EMERGENCY AND STUDENT HEALTH INFORMATION

Student's name _____ Birthdate _____ Gender ____ Grade/Teacher _____

Parent/Guardian _____ Phone _____ Cell _____

Email address _____

Health Care Provider _____ Phone _____

Emergency Contact _____ Phone _____

Emergency Contact _____ Phone _____

☐ YES ☐ NO My student has a life-threatening health condition		☐ My student has NO HEALTH CONCERNS at this time	
☐	ADD/ADHD	☐	Diabetes (see below)
☐	Autism Spectrum Disorder	☐	Dietary concerns
☐	Allergies (see below)	☐	Feeding support
☐	Asthma (see below)	☐	Frequent headaches/migraines
☐	Bladder/kidney or bowel concerns	☐	Hearing problem
☐	Blood disorder	☐	Heart condition (see below)
☐	Brain (injury, conditions, surgery, etc.)	☐	Other health conditions
☐		☐	Physical disabilities
☐		☐	Seizure disorder (see below)
☐		☐	Skin condition/eczema
☐		☐	Social/Emotional/Behavioral concerns
☐		☐	Stomach/intestinal concerns
☐		☐	Vision problems
☐		☐	Glasses/contacts

Allergies:☐ Bee sting ☐ Food allergies (specify) _____ ☐ Other allergies (specify) _____

Describe allergic reaction and treatment _____

*Has your child been advised by your Healthcare Provider to keep an EpiPen? ☐ Yes ☐ No**Asthma** Please check applicable triggers: ☐ Allergies ☐ Exercise ☐ Irritants ☐ Respiratory infections ☐ Weather changes****ALERT TO PARENTS/GUARDIANS**** The school **must know of LIFE-THREATENING** conditions (for example severe allergy with anaphylaxis, diabetes, heart condition, seizure disorder, asthma) prior to the start of school as these require an additional plan per RCW 28.A210.320. Contact the school nurse to begin the process.

Please list other health conditions: _____

MEDICATIONS List any medications taken.Medication: _____ For: _____ ☐ Home ☐ SchoolMedication: _____ For: _____ ☐ Home ☐ SchoolMedication: _____ For? _____ ☐ Home ☐ SchoolMedication: _____ For? _____ ☐ Home ☐ School****Policy for Medication at School**** 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, available at TSD schools or, online at the TSD website.****I** permit my child's school/child care to add immunization information into the Immunization Information System to help maintain my child's records and for the release of information.

Parent/Guardian Signature: _____ Date: _____

****If** your child is ill/injured at school, we will contact the parent/legal guardian or emergency contact person, if possible, and call 911 if the injury or illness warrants it. I consent to releasing 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.

Parent/Guardian Signature: _____ Date: _____