



# 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 \_\_\_\_\_

<input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> My student has a life-threatening health condition	<input type="checkbox"/> My student has NO HEALTH CONCERNS at this time
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Student Medical History: Does your student have any of the following? Please check:

ADD/ADHD	Diabetes (see below)	Physical disabilities
Autism Spectrum Disorder	Dietary concerns	Seizure disorder (see below)
Allergies (see below)	Feeding support	Skin condition/eczema
Asthma (see below)	Frequent headaches/migraines	Social/Emotional/Behavioral concerns
Bladder/kidney or bowel concerns	Hearing problem	Stomach/intestinal concerns
Blood disorder	Heart condition (see below)	Vision problems
Brain (injury, conditions, surgery, etc.)	Other health conditions	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  School

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Medication: \_\_\_\_\_ For? \_\_\_\_\_  Home  School

Medication: \_\_\_\_\_ 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: \_\_\_\_\_