



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 \_\_\_\_\_

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