



LIBERTY SCHOOL DISTRICT #362

Student Health Information

Phone: (509) 245-3211
Fax: (509) 245-3530
29818 S. North Pine Creek Road
Spangle, Wa 99031

Last Name:		First Name:		Birthdate:	
School:	☐ Elementary School	☐ Middle School	☐ High School	Teacher (if known):	
				Grade:	
Parent/Guardian:				Phone:	
Emergency Contact:				Phone:	

Allergies (foods/meds)	☐ No ☐ Yes	Specify:	☐ Epi Pen ☐ Food intolerance
Allergies (bee sting)	☐ No ☐ Yes	Notes:	☐ Local reaction ☐ Epi Pen
Allergies (seasonal)	☐ No ☐ Yes	Symptoms:	☐ Takes medication
Asthma	☐ No ☐ Yes	Notes:	☐ Inhaler needed at school
Blood/bleeding disorder	☐ No ☐ Yes	Specify:	☐ medications needed at school
Cancer	☐ No ☐ Yes	Specify:	
Cardiac	☐ No ☐ Yes	Condition/Type:	
Developmental concern	☐ No ☐ Yes	Specify:	
Diabetes	☐ No ☐ Yes	Type:	☐ Insulin needed at school
Epilepsy or seizures	☐ No ☐ Yes	Date/type of last seizure:	☐ Takes medication
Gastrointestinal concern	☐ No ☐ Yes	Specify:	
Headaches	☐ No ☐ Yes	Specify:	☐ Migraines
Hearing concern	☐ No ☐ Yes	Specify:	☐ Wears hearing aid(s)
Heart Condition	☐ No ☐ Yes	Specify:	
Mental health diagnosis	☐ No ☐ Yes	Specify: ☐ Anxiety ☐ Depression ☐ ADHD	☐ Medication needed at school
Musculoskeletal concern	☐ No ☐ Yes	Specify:	
Physical restrictions	☐ No ☐ Yes	Specify:	
Previous concussion	☐ No ☐ Yes	Cause and Date:	
Seizures	☐ No ☐ Yes	Type:	
Serious injury/ illness	☐ No ☐ Yes	Specify:	
Urinary system concern	☐ No ☐ Yes	Specify:	
Vision concern	☐ No ☐ Yes	Specify:	☐ Wears corrective lenses
An IEP or 504 plan	☐ No ☐ Yes	Specify:	
Other conditions or any daily medications taken at home	☐ No ☐ Yes	Specify:	

IF ANY OF THE ABOVE HEALTH CONDITIONS ARE LIFE-THREATENING, RCW28A.210.320 requires that licensed healthcare provider orders, medications, and/or treatments and a nursing care plan MUST be in place before a student attends school.

Also, any medications (prescription or over-the-counter) will require a completed medication authorization form on file signed by the physician and parent. Blank forms are available in the school offices or can be downloaded www.libertysd.us

Release Statement

- I understand that the information given herein may be shared with appropriate school staff to provide for the health and safety of my child.
- I authorize Liberty School District staff to contact health care professionals, including 911, if necessary, and I further authorize those contacted to initiate necessary treatment for emergency care, including transportation to the hospital or clinic at my expense.
- I understand that Liberty School District, its employees and Board of Directors assume no liability of any nature in relationship to transporting or treatment of my child.
- I give permission to my child's school to add immunization information into the Washington State Immunization Information System (IIS) to help maintain my child's lifetime immunization record.
- To my knowledge the above information is correct and complete and I understand to notify school officials immediately for any changes to any/all information.

Parent/Guardian Signature: _____ Date: _____

Office Use Reviewed by: _____ Date: _____ Notes: _____