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)	☐	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

Medication: _____ For: _____ ☐ Home ☐ School

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: _____