

## STUDENT HEALTH INFORMATION

The information below is to help school staff understand any health concerns that might affect your child's safety or learning

Student's Name: \_\_\_\_\_  
First Middle Last

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian name(s): \_\_\_\_\_

Daytime phone: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

### MEDICAL HISTORY Please mark if you child has any of the following health conditions:

- ☐ My child has **NO HEALTH PROBLEMS**
- ☐ Asthma ☐ Will need inhaler at school ☐ Seen in hospital/Emergency Room in last five years for asthma
- ☐ Severe allergy requiring Epi-pen? Allergy to : ☐ Food ☐ Bees/Insects ☐ Plants ☐ Animals ☐ Drugs
- ☐ Diabetes ☐ requires insulin injection
- ☐ Seizure disorder
- ☐ Heart Condition
- ☐ Frequent or severe headache
- ☐ Behavior or emotional concerns
- ☐ ADD/ADHD
- ☐ **Other – please explain any health concerns you think we should know about at school:**
- Does your child wear hearing aids? ☐ Yes ☐ No Does your child wear glasses/contacts? ☐ Yes ☐ No
- Do any of the above condition(s) limit/affect your child at school? ☐ No ☐ Yes, explain:

### LIFE-THREATENING CONDITIONS

Does your child have a life-threatening health condition? ☐ No ☐ Yes\* Describe:

If yes, a meeting with the school nurse is required. Washington State Law requires that medication or treatment orders and a health care plan be in place prior to starting school.

### MEDICATION

Does your child take any medications? ☐ No ☐ Yes, name medication:

Reason for taking medication:

Will medication be needed at school, please contact the school for the "Medication Authorization" form. **This form must be completed every year before any medication may be administered at school.**

### MEDICAL

Does your child have a health care provider? ☐ Yes ☐ No

Name of child's health care provider \_\_\_\_\_ Phone number \_\_\_\_\_

### DENTAL

Does your child have a dentist? ☐ Yes ☐ No

Name of child's dentist \_\_\_\_\_ Phone number \_\_\_\_\_

### INSURANCE

Does your child have medical insurance coverage? ☐ Yes ☐ No ☐ Don't know

Does your child have dental insurance coverage? ☐ Yes ☐ No ☐ Don't know

Would you like assistance finding insurance for your child? ☐ Yes

**AUTHORIZATION FOR SHARING HEALTH INFORMATION** I understand that the information give above may be shared with some school staff to provide for the health and safety of my child.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

RN initials \_\_\_\_\_ Date \_\_\_\_\_