Steilacoom Historical School District Student Health Information 2026-27

Student Name:_____DOB:_____Grade:_____Gender: ☐ M ☐ F

Washington State law requires that students with life-threatening health conditions, where the conditions would "put the child in danger of death during the school day", have medication/treatment orders and a nursing plan in place at school before your child can attend school.

HEALTH HISTORY – SPECIAL HEALTH CARE PLANNING

☐ **My student has NONE of the health concerns/conditions listed below.**

☐ **Diabetes (Form A) – Date of diagnosis:_____ My student has:** ☐ insulin pump ☐ insulin pen ☐ injected insulin

☐ **Seizure Disorder (Form B) –** My student needs emergency medication for Seizures. ☐ **Yes** ☐ **No**

☐ **Special Health Care Planning -** My student has special health care needs such as – wheelchair, tube feedings, breathing tube, catheter, intravenous tubes or other. Please describe your student's condition(s):

_____

HEALTH HISTORY – ASTHMA & ALLERGIES

☐ **My student has NONE of the health concerns/conditions listed above.**

☐ **Asthma (Form C) -** - (If this box is checked, please answer the following questions):

Yes ☐ No ☐ Does student use rescue inhaler routinely for asthma symptoms?

Yes ☐ No ☐ Does student use an inhaler before physical activity (PE, sports)?

Yes ☐ No ☐ **Does student need an inhaler while at school?**

☐ **Allergies**

Allergen(s):_____

☐ **Does student have an Epi Pen? (Form D)** ☐ **Yes** ☐ **No**

OTHER HEALTH CONDITIONS

☐ **My student does not have any other health concerns/conditions.**

Identify any other health conditions: _____

Has the student ever visited an emergency room or hospital for a medical issue? YES / NO (circle)

If yes, date and reason for visit:_____

MEDICATION

Students requiring medications during the school day (herbal, over the counter, or prescription) MUST have a written health care provider order and written parent consent. If a health professional and a student's parent request that a student be permitted to carry his/or her own medication and/or be permitted to self-administer the medication, this may be allowed under limited circumstances with principal/school nurse permission. The **Medication at School (Form E)** form needs renewed at the beginning of each school year. **Please list any medications taken by student:**

Medications: _____

I give permission to my child's school to add immunization information into the Washington State Immunization Information System to help the school maintain my child's record. ☐ Yes ☐ No

In order to provide a safe and healthy environment for your student, the health room may need to share information about your student's health condition with teachers and essential school staff. If you have questions, please contact the school's Health Room.

Your Name (printed) _____ Signature _____ Date _____

Relationship to Student _____ E-mail Address _____

Review Date: _____