

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 your child has any of the following health conditions:

- ____ 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 aides? 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:

My child has NO HEALTH PROBLEMS

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 medication? No Yes, name of medication:

Reason for taking medication:

Will medication be needed at school? No Yes*

*** If your child needs medication 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 given above may be shared with some school staff to provide for the health and safety of my child.

Parent/Guardian Signature _____ Date _____