

# Methow Valley School District

Methow Valley Elementary School 509.996.2186 / fax 509.996.9202  
Liberty Bell High School 509.996.2215 / fax 509.996.3609

2012-13

## STUDENT HEALTH INFORMATION

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

<b>Student's Name:</b> _____ <i>First Middle Last</i>
<b>Date of Birth:</b> _____ <b>Sex:</b> _____ <b>Grade:</b> _____
<b>Parent/Guardian name(s):</b> _____
<b>Daytime phone: #1</b> _____ <b>#2</b> _____ <b>#3</b> _____

### MEDICAL HISTORY

Please mark if your child has any of the following health conditions:

Does your child have a life-threatening health condition?  No  Yes— If yes, a meeting with the school nurse is required so that medication or treatment orders and a health care plan may be in place prior to starting school.

\_\_\_ 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 health concerns you want us to know about:

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

### 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 your health care provider or the school for the "Medication Authorization" form which 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  No

**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 \_\_\_\_\_