

Student's Name: _____ Birthdate: _____ Gender: _____ Grade: _____ Teacher: _____
Last First Middle

My student has NO HEALTH CONCERNS at this time

SPECIAL HEALTH CARE PLANNING

If anything is checked below, please send this form to school nurse and obtain additional necessary forms. New forms are required each school year **dated after July 1st**

Diabetes- Date of Diagnosis: _____ My student has: Insulin pump Insulin pen Injected insulin

Seizure Disorder requiring Medication- Name of Medication: _____

Special Health Care Planning- My child has special health care needs such as wheelchair, tube feedings, breathing tube, catheter, intravenous tubes or other. Please describe condition(s). _____

LIFE-THREATENING HEALTH CONDITIONS

If anything checked below, please send this form to school nurse and obtain additional necessary forms. New forms are required each school year **dated after July 1st**

Allergy/Anaphylaxis- Severe with EPI-PEN/AUVI-Q prescription (for example: food, insect stings)
 Allergens: _____ Other: _____

Asthma- Severe including RESCUE INHALER prescription, hospitalization(s) within the past year, STEROIDS (prednisone) in the past year
 (If mild or moderate asthma, see below "NON LIFE THREATENING HEALTH CONDITIONS")

ALERT TO PARENTS/GUARDIANS: The school **must know** of **LIFE THREATENING conditions** (for example: severe allergy with anaphylaxis, diabetes, asthma) **prior to the start of school** as these may require an additional plan (per RCW 28A.210.320). Contact your school nurse to begin the process.

NON LIFE-THREATENING HEALTH CONDITIONS

Please circle any of these conditions which your child has or has had:

- ADD/ADHD Mild/Moderate Allergies Mild/Moderate Asthma
- Blood Disorder Bowel/Bladder Cancer Depression/Anxiety Dental
- Hearing Condition Heart Condition Orthopedic/Bone Condition
- Social/Emotional/Behavioral Serious Injury Vision Condition Other

Please explain: _____

MEDICATIONS List any medications taken. A physician's order is required for each medication taken. A new order **dated after July 1st** is required every school year.

Medication: _____ For: _____ Home School
 Medication: _____ For: _____ Home School
 Medication: _____ For: _____ Home School
 Medication: _____ For: _____ Home School

CONTACT INFORMATION

Health Care Provider: _____ #: _____ Dentist: _____ #: _____

Parent/Legal Guardian Printed Name	Cell Phone	Work Phone	Additional Number(s) or Email
1.			
2.			

I consent to the care of my child and to the release of medical information related to my child to school or medical personnel, as needed, to ensure my child's safety at school. I understand that it will be my responsibility to arrange for payment for medical care, should my child be ill/injured. I have read and understand this form.

Parent/Legal Guardian Sign Here: _____ **Date:** _____