STUDENT HEALTH RECORD

GRADE Selec

SCHOOL YEAR Select

Student Name: (Last)_____ **(First)**_____ **Birthdate:**_____

Parent/Guardian Name: _____ **Phone 1:**_____ **Phone 2:**_____

☐ My child **DOES NOT** have any health concerns or conditions. **Review all sections before checking.** (If nothing else applies, skip to section E for signature)

A. Life-Threatening Conditions (check appropriate box below):

If your child has a **SERIOUS health condition, TELL YOUR SCHOOL NURSE NOW**. State Law (RCW 28A.210.320) requires current medical orders, medications, and a health care plan must be in place prior to attending school. New orders are required each school year.

☐ My child has the following life-threatening health condition(s) - Check boxes below:

- ☐ **Life threatening allergy with Epi-pen** (epinephrine) prescribed
  List of life-threatening allergens:_____
- ☐ **Asthma with rescue inhaler** needed at school
- ☐ **Diabetes**: Type 1 ☐ **or** Type 2 ☐
- ☐ **Seizure Disorder** Type:_____ Rescue medication prescribed: ☐ Yes **or** ☐ No
- ☐ **Other serious health condition**(s) (e.g. heart or lung conditions, blood disorders, cancer, transplant). Please describe: _____

B. Other Health Conditions (check appropriate box below):

- ☐ Other allergies (e.g. medication, pollen): _____
- ☐ Food sensitivities or intolerances: _____
- ☐ Skin conditions or sensitivities: _____
- ☐ Gastrointestinal conditions (e.g. celiac, encopresis, constipation, IBS, other): _____
- ☐ Neurological conditions (e.g. ADHD, Autism Spectrum Disorder, TBI, migraines, other): _____
- ☐ Vision or Hearing concerns: _____ Glasses or contacts ☐ Hearing Aids ☐
- ☐ Mental or Behavioral health concerns: _____
- ☐ Other health concerns: _____

C. Special Health Care Planning (check appropriate box below):

Treatment orders from a doctor are required for most special health care needs. Please contact your school nurse to discuss.

☐ Tube feeding ☐ Tracheostomy ☐ Catheter ☐ Other Medical device or treatment: _____

☐ Mobility aids (e.g. wheelchair, walker, crutches, brace): _____

D. Medications: Includes prescription, supplements, over the counter medications

Does your child need to take medication daily or as needed at school? ☐ No ☐ Yes

If **Yes**, please list: _____

A signed medical order form must be at school for all medications (RCW 28A.210.206)

E. Signature

I understand that the information provided will be shared with appropriate school staff who need to know in order to provide for the health and safety of my student. I understand the nurse may communicate with my child's Healthcare Provider for any questions or clarifications to the medical order or medical diagnosis to assist in the development of an Individual Health Plan or Emergency Care Plan, if applicable. 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.

Parent/Legal Guardian Signature: _____ **Date:**_____