Anacortes School District

STUDENT HEALTH INFORMATION

Information on this form is to be filed out (updated) for each new school year. Please complete both sides of this form and return to you school as soon as possible.

Name: _____ Birthdate: _____ Gender: _____
Last First MI

School: _____ Grade: _____ Today's Date: _____

LIFE THREATENING CONDITIONS

Does your child have a life-threatening health condition? Yes* __ No __

If yes, a meeting with the school nurse is required prior to starting school.

□ Asthma *Severe – (If this box is checked, please answer the following questions.)

Yes □ No □ Does child use rescue inhaler routinely for asthma symptoms?
Yes □ No □ Has your child been hospitalized for asthma in the past year?
Yes □ No □ Has your child used steroids (Prednisone) for asthma symptoms in the past year?

If mild or moderate asthma, see box below - HEALTH CONDITIONS

□ Allergy/Anaphylaxis - *Severe - with Epipen/epinephrine prescription (for example: food, insect stings.)
Allergen(s): _____

Other: _____

□ **Diabetes – Date of diagnosis: _____ My student has** □ insulin pump □ insulin pen □ injected insulin

□ **Seizure Disorder -** My student needs emergency medication for **Seizures.** 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 your child's condition(s): _____
_____

ALERT TO PARENTS/GUARDIAN: *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 Individual Health Plan (per RCW 28A.210.320). Contact your school nurse to begin the process for the student health care plan.*

□ My child has NONE of the health concerns/conditions listed above.

HEALTH CONDITIONS

Check any of these conditions which your child has or has had:

□ ADD/ADHD	□ Blood Disorder	□ Concussions	□ Hearing/Vision	□ Orthopedic/Bone
□ Allergies *mild or moderate (circle one)*	□ Bowel/Bladder	□ Dental	□ Heart problems	□ Skin Condition
□ Asthma *mild or moderate (circle one)*	□ Cancer	□ Headaches/Migraines	□ Mental Health Conditions	□ Other

If you have checked any of the above medical conditions/concerns, please explain: _____

_____

_____

Has your student ever visited a hospital or an emergency room for the medical issue? YES / NO (circle) If yes, date _____

_____

□ My child has NONE of the health concerns/conditions listed above.

PLEASE SEE OTHER SIDE

MEDICATONS

List any medications taken by student:

Medication Taken: _____ For _____ At Home At School

Medication Taken: _____ For _____ At Home At School

Medication Taken: _____ For _____ At Home At School

If your student needs to take any medication (over the counter, prescription, herbal) at school, a medication authorization form is required. This form must be completed by physician and parent prior to any medication being brought to school. This form is available through the ASD web site or any school office.

SHARING HEALTH CARE INFORMATION

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

CONTACT INFORMATION

Please provide correct and current contact numbers and inform school office of any changes.

Name of Health Care Provider: _____ Phone: _____

Name of Dentist: _____ Phone: _____

_____

Student's Name

_____ _____

Parent/Guardian name printed Signature

_____ _____

Relationship to student Today's date