2012-2013

Wilson Creek School District

P. O. Box 46 Wilson Creek WA 98860-0046 Phone: 509-345-2541 FAX: 509-345-2288

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 NAME: _____ _____ _____
First *Middle* *Last*

DATE OF BIRTH: _____ **Sex:** _____ **Grade:** _____

PARENT/GUARDIAN NAME *(please print)*: _____

Parent/Guardian Phone or other contact information: _____

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?
____ 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.

Do any of the above condition(s) limit/effect your child at school? ❒ No ❒ Yes, explain:
Does your child wear hearing aides? ❒Yes ❒No Does your child wear glasses/contacts? ❒Yes ❒No

OR

❒ 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? ❒ Yes* ❒ No

*** If your child needs medication at school, please contact the school for the "Medication Authorization" form. The form must be completed every school year before any medication may be administered by student or staff at school.**

OPTIONAL:

Medical Care

Does your child have a health care provider? ❒ Yes ❒ No
In the last 6 months has your child seen a health care provider? ❒ No ❒ Yes, please explain:

Dental Care

Does your child have a dentist? ❒ Yes ❒ No
Has your child had a dental exam in the last 12 months? ❒ Yes ❒ No ❒ Don't know

Insurance for Health Care

Would you like help 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 _____

School staff review (date and initials) _____ *Date RN notified (if needed)* _____