

Wilson Creek School District

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

STUDENT HEALTH INFORMATION 2017-2018

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): _____

Daytime Phone: #1 _____ #2 _____ #3 _____

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
 Diet Controlled food allergy / Intolerance. Which foods? _____
 Diabetes requires insulin injection _____ Frequent or severe headache
 Seizure disorder _____ Behavior or emotional concerns
 Heart condition _____ ADD/ADHD
 Other - please explain any health concerns you think we should know about at school.

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

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