Olympia School District

STUDENT HEALTH INFORMATION

Nurse Reviewed (Initials) ________

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 the 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 is checked below, please send this form to the 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 check 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: ____

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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 ☐
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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:** ___________________