

STUDENT HEALTH CONCERNS

STUDENT NAME: _____ GRADE: _____ HM PHONE: _____

- DOES YOUR CHILD HAVE A LIFE THREATENING HEALTH CONDITION? YES ___ NO ___ *
- DOES YOUR CHILD CURRENTLY HAVE HEALTH INSURANCE? YES ___ NO ___
- MY CHILD HAS NO HEALTH CONCERNS AT THIS TIME _____.

(Include all health concerns necessary for educational planning and potential need for emergency care.)

<p>Allergies: Severe</p> <p><input type="checkbox"/> Bee Sting Allergy (EE, EG) <input type="checkbox"/> Severe and needs EpiPen at school and medical follow-up for a bee sting.</p> <p><input type="checkbox"/> Food Allergy (ED, EG) <input type="checkbox"/> Severe reaction to: _____, and needs EpiPen at school and medical follow-up.</p> <p>Asthma:</p> <p><input type="checkbox"/> Severe and needs EpiPen at school (RD, EG) <input type="checkbox"/> Needs medication at school (RC) <input type="checkbox"/> Does not need medication at school. (RB)</p> <p>Attention Deficit Disorder: (NB)</p> <p><input type="checkbox"/> Needs medication at school and home <input type="checkbox"/> Medication at home only <input type="checkbox"/> Diagnosed but not medicated.</p> <p>Behavioral concerns- (significant) (PJ)</p> <p><input type="checkbox"/> Please List: _____</p> <p>List: _____</p> <p>Bowel/Bladder concerns (current) (GI and/or UD)</p> <p><input type="checkbox"/> Please List: _____</p> <p>Diabetes:</p> <p><input type="checkbox"/> Insulin Dependent (Type 1). (EK) Will need a school program set-up.</p> <p><input type="checkbox"/> Non-insulin (Type 2) (EL) <input type="checkbox"/> Other blood sugar problems: Please List: _____</p>	<p>Hearing concerns:</p> <p><input type="checkbox"/> Past <input type="checkbox"/> Present</p> <p><input type="checkbox"/> Wears hearing aid in __right __left ear (YB) <input type="checkbox"/> Needs classroom accommodation.</p> <p>Heart Problems: (CG)</p> <p><input type="checkbox"/> Please List: _____</p> <p>Seizures:</p> <p>Type: _____</p> <p><input type="checkbox"/> Takes medication at home (NP) <input type="checkbox"/> History of seizures, but not presently medicated (Type: _____)</p> <p>Vision Problems:</p> <p><input type="checkbox"/> Blind in one eye: __Right __Left (YD) <input type="checkbox"/> Wears glasses or contacts <input type="checkbox"/> Other eye conditions (YE): _____</p> <p>Physical /health restrictions that would limit activity: (Requires Health Care Provider orders)</p> <p><input type="checkbox"/> Please _____</p> <p>Other:</p> <p><input type="checkbox"/> Health concerns that would affect school performance. Please list: _____</p> <p><input type="checkbox"/> Accommodations your child may need for a disability/health concern: _____</p>
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- All health concerns will be brought to the attention of the school nurse.
- If medication is needed at school, you must submit medication forms that are completed by the Health Care Provider before medication can be given or carried on campus.
- The above checked health concerns may be shared with school personnel on a “need to know basis.”
- Insurance information may be shared with Whatcom Alliance for Healthcare Access (WAHA.)

***Please note: This updated student health form will replace any data we have received previously on your child with the exception of “life threatening health conditions” which will require Health Care Provider documentation/orders.**

Authorization for Emergency Procedure

If the parents and authorized physician named on the registration record cannot be reached at the time of an emergency, and the immediate observation or treatment is urgent in the judgment of the school authorities, I authorize and direct the school authorities to send the pupil (properly accompanied) to the hospital or doctor most easily accessible. I understand that I will assume full responsibility for the payment of any services rendered.

Name of Health Care Provider: _____ **Phone:** _____

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