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.)

Allergies: Severe

Bee Sting Allergy (EE, EG)

____ Severe and needs EpiPen at school and medical follow-up for a bee sting.

Food Allergy (ED, EG)

_____ Severe reaction to: ________________ _________________, and needs EpiPen at school and medical follow-up.

Asthma:

_____ Severe and needs EpiPen at school (RD, EG)

_____ Needs medication at school (RC)

_____ Does not need medication at school. (RB)

Attention Deficit Disorder: (NB)

_____ Needs medication at school and home

_____ Medication at home only

_____ Diagnosed but not medicated.

Behavioral concerns- (significant) (PJ)

_____ Please List: _________________________ ____________________________________

Bowel/Bladder concerns (current) (GI and/or UD)

_____ Please List: _________________________ ____________________________________

Diabetes:

_____ Insulin Dependent (Type 1). (EK)

____

Will need a school program set-up.

____

_____ Non-insulin (Type 2) (EL)

_____ Other blood sugar problems:

Please List: _________________________

____

Hearing concerns:

_____ Past _____ Present

_____ Wears hearing aid in __right __left ear (YB)

_____ Needs classroom accommodation.

Heart Problems: (CG)

_____ Please List: __________________________ _____________________________________

Seizures:

Type:_______________________________________

_____ Takes medication at home (NP)

_____ History of seizures, but not presently medicated (Type: _____________________________)

Vision Problems:

_____ Blind in one eye: __Right __Left (YD)

_____ Wears glasses or contacts

_____ Other eye conditions (YE): ______________ _____________________________________

Physical /health restrictions that would limit activity:

(Requires Health Care Provider orders)

_____ Please List:___________________________ _____________________________________ _____________________________________

Other:

_____ Health concerns that would affect school performance. Please list: ________________

______ Accommodations your child may need for a disability/health concern: ________________

- 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: __________________