Confidential Emergency Health Information

Name _____ DOB _____ Sex M F
Last First MI

School _____ Grade _____ Teacher _____

ALERT TO PARENTS/GUARDIANS: If your child has a life-threatening health condition (severe bee sting allergy, severe food allergy, severe asthma, unstable diabetes, severe seizures etc.), Washington State Law SHB 2834 requires that a medication or treatment order and a Health Care Plan be in place before your child's first day of school each year. Please, immediately contact your child's School Nurse.

In order to provide a safe and healthy environment for your child this information will be accessible to the following people: Principal, nurse, your child's teachers, secretaries, personnel responsible for health room coverage, and medical emergency personnel.

A. Medical History (check the ones that apply to your child and describe under the comment section)

- ☐ ADHD
- ☐ Anxiety/Depression
- ☐ Asthma
- ☐ Autism
- ☐ Bee Sting Allergy
- ☐ Bleeding Disorder
- ☐ Cerebral Palsy
- ☐ Color Blindness
- ☐ Diabetes
- ☐ Epinephrine Auto Injector
- ☐ GI Condition
- ☐ Hearing Concern
- ☐ Heart Condition
- ☐ Hyperventilation
- ☐ Migraine Headache
- ☐ Orthopedic Concern
- ☐ Seizures
- ☐ Vision Concern
- ☐ Other: _____

PE Activity:
☐ Limited
Explain: _____

Comments: _____

B. ALLERGIES List all allergies your child has including allergies to medications/bee stings/food.

Cause of the allergy _____ Treatment _____

Cause of the allergy _____ Treatment _____

Cause of the allergy _____ Treatment _____

C. MEDICATION: Is medication given **at home?** Yes ☐ No ☐

Name of medication 1) _____ Used to treat: 1) _____

2) _____ Used to treat: 2) _____

Is medication needed **at school?** Yes ☐ No ☐

Name of medication 1) _____ Used to treat: 1) _____

2) _____ Used to treat: 2) _____

****Is your student taking any herbal medicine?** Yes ☐ No ☐

Name of medication. 1) _____ Used to treat: 1) _____

Before medication can be administered at school, a medication administration form, available in the office and online, must be completed by the parent and licensed health care provider and kept on file.

OVER >

D. List any operations, injuries, or hospitalizations with dates:_____

_____

E. Does your son/daughter wear glasses? Yes ☐ No ☐ Contact Lenses? Yes ☐ No ☐

F. Name of Physician/Health Care Provider: _____ Phone # _____

Name of Dentist: _____ Phone # _____

Hospital Preference: _____

Insurance Carrier: _____

G. Parents Name: _____ _____

	Parent/Guardian 1	Parent/Guardian 2
Home Phone:	( )	( )
Work Phone:	( )	( )
Cell Number:	( )	( )
E-mail:		

Home Address: _____

City: _____ Zip Code: _____

Student lives with: Both ☐ Parent/Guardian 1 ☐ Parent/Guardian 2 ☐

Other: ☐ Name:_____ Relationship:_____ Phone#_____

H. IN THE EVENT OF A MEDICAL EMERGENCY, IF A PARENT/GUARDIAN CANNOT BE REACHED, PLEASE CONTACT: (Provide a local contact)

Name: _____ Relationship: _____

Home Phone Number: ( ) _____ Cell Number: ( ) _____

If the parent/guardians cannot be reached at the time of an emergency and if an immediate observation or treatment is urgent in the judgment of the school authorities, I authorize and direct the school authorities to send the child (properly accompanied) to the hospital or licensed health care provider most accessible.

PARENTS/GUARDIAN SIGNATURE: _____ **DATE:** _____