



# SCHOOL NURSE HEALTH INFORMATION 2020-21

To make school a safe and healthy place for your child this private form will be seen by the School Nurse, school staff who help your child, and emergency medical personnel.

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Last First MI

School: \_\_\_\_\_ Grade for 2020-21: \_\_\_\_\_ Date: \_\_\_\_\_

### **SERIOUS HEALTH CONDITIONS (check box below):**

If your child has a **SERIOUS health condition, TELL YOUR SCHOOL NURSE NOW.** State Law (RCW 28A.210.320) says medication, medical orders, and a health care plan must be in place **before** the start of school.

- My child does not have any SERIOUS health conditions that will affect them at school.
- My child has the following SERIOUS health condition(s) – Check boxes below:
  - Allergy** (life threatening: requires an epinephrine prescription such as Epi Pen or Auvi-Q? \_\_\_\_ Yes or no?  
Allergic to: \_\_\_\_\_ Date of last reaction: \_\_\_\_\_)
  - Asthma** – Will your child require a rescue inhaler (such as Albuterol) at school? \_\_\_\_ Yes or no?
  - Heart condition** and restrictions (if any): \_\_\_\_\_
  - Diabetes** (Date of diagnosis: \_\_\_\_\_)
    - Insulin Pump
    - Insulin Pen
    - Insulin via syringe
  - Seizure Disorder** (Date of diagnosis: \_\_\_\_\_) (Date of last seizure: \_\_\_\_\_)  
Type: \_\_\_\_\_ Rescue Medication: \_\_\_\_ Yes or no?
  - Other**, including overnight hospitalizations in past 12 months: -- Please describe condition:  
\_\_\_\_\_

### **OTHER HEALTH CONDITIONS (check appropriate box below):**

- My child does not have any other health conditions that will affect them at school.
- History of a **Concussion** (diagnosed by a health care provider) - Date of concussion \_\_\_\_\_
- Hearing concerns?       Does your child wear hearing aids?       Does your child have a known hearing loss?
- Vision concerns?                       Glasses                       Contacts
- Food sensitivity: \_\_\_\_\_  Other Allergies (e.g. medication, pollen): \_\_\_\_\_
- Other: \_\_\_\_\_

### **MEDICATIONS: Prescription, supplements, over-the-counter (pills, eye drops, ointments, etc.):**

Does your child need to take medication every day at school?      Yes  No

Does your child need to take medication at school sometimes?      Yes  No

If **Yes**, a signed medical order form must be at school, for all medications (RCW 28A.210.206 and BSD Policy 4320).

### **CONTACT INFORMATION: Please provide correct & current contact numbers.**

	PARENT/GUARDIAN	PARENT/GUARDIAN
Parents/Guardians:		
Primary contact phone:		
Email:		

Signature (Parent/Guardian): \_\_\_\_\_ Date: \_\_\_\_\_