

HEALTH INFORMATION

Shorecrest High School

The following information is considered confidential but will be shared with staff that will be in contact with and responsible for your child during the school day on a need to know basis.

Please complete and return the 1st week of school

Name of Student: _____ Grade _____ Birth date: _____
Doctor's Name: _____ Phone Number _____

Does your child have any life-threatening conditions*? No _____ Yes _____ (If yes, contact School Nurse)

(* Examples of Life Threatening Conditions are severe food or bee sting allergies, diabetes, severe asthma, and severe seizures. Students must have a treatment order form from their provider, emergency care plan, medication order form and the required medication and equipment at school by the first day of school, in order to attend. RCW 28.A.210.320)

Check "Yes" or "No" for each of the following questions. Please explain any "Yes" answers.

Asthma: (if yes, list triggers) No _____ Yes _____

Requiring visit to hospital in last year? No _____ Yes _____

Will your student carry an inhaler? No _____ Yes _____

Heart Condition or Blood Disease No _____ Yes _____

Diabetes (if yes, contact school nurse) No _____ Yes _____

Head Injury/Concussion (Date of Injury) No _____ Yes _____

Seizures (if yes, contact school nurse) No _____ Yes _____

Allergies No _____ Yes _____

Seasonal/environmental No _____ Yes _____

Food-list foods No _____ Yes _____

Insect No _____ Yes _____

List medications used for allergies: _____

Mental Health Concerns/Counseling No _____ Yes _____

Hearing/Vision concerns or loss No _____ Yes _____

Migraine/Headaches No _____ Yes _____

Speech or Language Concerns No _____ Yes _____

Bone, Joint, or Muscle Problems No _____ Yes _____

Is any medication needed at home? No _____ Yes _____ Name of medication: _____

Reason for use: _____

Is any medication needed at school? No _____ Yes _____ Name of medication: _____

Reason for use: _____

State law requires written permission from a licensed health care provider with prescriptive authority and the parent before any medication, prescription or over-the counter, may be taken at school. Forms are available from the Shorecrest Health Office.

Please relate any other health information you would like the nurse or school to be aware of, such as significant injuries or chronic conditions likely to affect your student at school. This information is considered confidential but will be shared with staff that will be in contact with and responsible for your child during the school day on a need to know basis.

Please feel free to contact the school nurse at 206-393-4308.

During the school year please notify the health office if your student is going to be absent due to an extended illness or significant injury or has a health issue that may impact their attendance.

Parent Signature: _____ Date: _____