ISSAQUAH SCHOOL DISTRICT 411

Confidential Emergency Health Information 2020-2021

Name: _____ **DOB:** _____

School: _____ **Grade:** _____

ALERT TO PARENTS/GUARDIANS: If your student has a life-threatening health condition (severe bee sting allergy, severe food allergy, severe asthma, unstable diabetes, severe seizures etc.), Washington State Law SHB2834 requires that a medication or treatment order and a Health Care Plan be in place before your student's first day of school each year. Please, immediately contact your student's School Nurse.

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

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

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

Other: _____

Does your student have any of the following Health Concerns?

*A severe allergy requiring a prescription for an Epi-pen™?	YES or NO
*A seizure disorder?	YES or NO
*A diagnosis of diabetes?	YES or NO
*An asthma diagnosis?	YES or NO
*A life-threatening health condition?	YES or NO

Comments: _____

B. ALLERGIES **List all allergies your student has including allergies to medications/bee stings/food:**

C. MEDICATIONS Is medication given **at home?** YES or NO

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

2) _____ Used to treat: 2)_____

Is medication needed **at school?** YES or NO

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

2) _____ Used to treat: 2)_____

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.

D. List any operations, injuries, or hospitalizations in the past three years:

_____

_____

_____

_____

E. Does your student wear glasses? YES or NO **Contact lenses?** YES or NO

F. Parent/Guardians:

Parent/Guardian 1 Name: _____

Family Primary Phone: _____

Phone 2: _____

Phone 3: _____

Email Address: _____

Parent/Guardian 1 Name: _____

Family Primary Phone: _____

Phone 2: _____

Email Address: _____

G. Emergency Contact:

Name: _____ Relationship: _____

Phone 1: _____ Phone 2: _____

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 student (properly accompanied) to the hospital or licensed health care provider most accessible.

Parent/Guardian Signature: _____

Date Signed: _____

Asterisk (*) denotes a required field