

ORCHARD PRAIRIE SCHOOL DISTRICT

HEALTH INFORMATION AND EMERGENCY MEDICAL CONTACT

Name _____ Birthdate _____ Grade _____
Last First MI Legal name (if different)

Address _____ Home Phone _____
Street City State Zip code

Is this a new address and/or phone number? Yes No Gender: Male Female

Student lives with: Both Parents Mother Only Father Only Mother & Stepfather Father & Stepmother
 Agency Self Legal Guardian Other _____

Parent/Guardian 1 name: _____ Parent/Guardian 2 name: _____

Parent/Guardian 1 phone: _____ Parent/Guardian 2 phone: _____

Parent/Guardian 1 cell phone: _____ Parent/Guardian 2 cell phone: _____

Emergency contact: _____ Phone: _____
Name Relationship to child

Emergency contact: _____ Phone: _____
Name Relationship to child

Licensed Healthcare Provider (LHP): _____ Phone: _____

Dentist: _____ Phone: _____

Please describe your child's current health status in detail below. Keep the school updated about any changes in your child's health or medication. If your child needs to take medication at school, please let the school nurse know. This includes overnight field trips or after-school sports events.

No health problems to my knowledge.

Current Health History:

Please answer by checking

	No	Yes	Mild	Moderate	Severe		
Does your child have vision problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Contacts	<input type="checkbox"/> Glasses
Does your child have hearing problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hearing aid(s)	

Check if your child has any of the following:

	No	Yes	Mild	Moderate	Severe
Allergy – food (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy – insect (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Condition (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explain if other issues exist (including learning disabilities) _____

IF ANY OF THE ABOVE HEALTH CONDITIONS ARE LIFE-THREATENING, RCW 28A.210.320 requires that licensed healthcare provider (LHP) orders, medications, and/or treatments and a nursing care plan must be in place before a student attends school.

Does your child need medication while at school or after-school functions? Yes* No If yes, explain: _____

Does your child take medications of any kind, anywhere? Yes* No If yes, explain: _____

Has your child had any serious injuries that impact school? Yes* No If yes, explain: _____

***Students requiring medication (prescription or non-prescription) at school MUST have a written order by a LHP and written parent consent. These forms are available at the school office.**

The school nurse must sometimes share health information with school staff. If you have concerns about sharing this information, please contact the school nurse.

I authorize Orchard Prairie School District staff to provide standard first aid, and to contact a LHP, dentist, or 911 if necessary. I further authorize those contacted to initiate necessary treatment for emergency care for my child, including transportation to the hospital. I understand that the Orchard Prairie School District, its employees, and Board of Directors assume no liability of any nature in relationship to the transporting or treatment of my child.

I permit the school to add information to the Washington State Immunization Information System to help maintain my child's record.

I agree to contact the school nurse about any changes in my child's health during the school year.

Parent/Guardian Signature _____ Date _____