Annual Health History / Emergency Information

(To be filled out and signed by Parent/Guardian for secondary school and extracurricular activities)

Student DOB Grade

Address City Zip

Parent/Guardian Name Phone (H) (W) (C)

Parent/Guardian Name Phone (H) (W) (C)

Health Care Provider Phone Preferred Hospital Insurance

In an emergency, if unable to reach parent/guardian, please contact:

Name Relationship Phone (H) (W) (C)

Name Relationship Phone (H) (W) (C)

○ Please check if this is new contact information and needs to be updated in Skyward.

Health Information **Please circle all that apply**

Asthma - Inhaler prescribed YES NO; Diabetes; Seizures; Heart Condition; Bleeding Disorder; Bone/Muscle Disorder;

Skin Condition; ADD/ADHD; Mental Health Condition; Learning Disability; Physical Disability; Other____________________

Safety Issues: Sleepwalking / Fainting/ Other____________________ Special Dietary Needs ____________________________

Allergies Epi-Pen prescribed YES NO; Circle Allergen: Peanut; Tree Nut; Other Food; Bee; Latex; Pollen; Animals; Drug; Other;

Please describe ____

Does your child have a life threatening condition? YES NO Describe ____

Current Medication(s)	Used to treat what condition	Taken at:	Home	School	Activity
			○	○	○
			○	○	○

DISTRICT POLICY FOR ADMINISTERING MEDICATION TO STUDENTS

Medications, prescriptive or over the counter, may be administered to students by building administrators or their designee(s) only with:

WRITTEN PERMISSION of the parent/ guardian AND a Licensed Health Care Provider's Order for Medication at School

I understand that licensed health care providers have Authorization for Medication at School forms available in their office or the forms are available at TSD schools and online at the TSD website.

Any additional medical information helpful for treatment or well-being of participant should be given on reverse side.

Tumwater School District Use Only:

Cabin/Sport________________________________

Counselor/Coach/Staff________________________

Med Auth Rcvd_______ Med Rcvd_______ Student Carries Med______ EAP/IHCP Rcvd_____

RN delegation/staff training required: Yes No

Staff Trained________________________ Date____

If your child is injured or has a serious illness during this activity, we will:
Call 911 if injury or illness warrants.
Contact parent or emergency contact person if at all possible. Document attempts.
Transport to hospital as needed, based on advice of medics on the scene, and obtain necessary treatment.

Follow parent/guardian instruction as noted on this form as closely as possible; our primary responsibility is student safety.
Any directions to the contrary should be specified on the reverse side of this form and signed.

Parent/Guardian Signature ______________________________ Date______________________________