



# ANNUAL EMERGENCY AND STUDENT HEALTH INFORMATION

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

**2020-2021**

Student Name	Birthdate	Gender	Grade	Teacher
Parent/Guardian Name	Address	City	Zip Code	Cell/Home #
Work #	Email			
Parent/Guardian Name	Address	City	Zip Code	Cell/Home #
Work #	Email			
Health Care Provider	Phone	Preferred Hospital	Dental Care Provider	Phone
Type of Medical Insurance (circle one)	Private	Military/Tricare	Apple Health/Medicaid	None
In an emergency and unable to reach parent/guardian, please contact:				
Emergency Contact Name	Address	City	Zip Code	Cell/Home #
Work #	Email			
Emergency Contact Name	Address	City	Zip Code	Cell/Home #
Work #	Email			

<p><b>Life –Threatening Conditions</b>          RCW 28A.210.320 requires every public school to prohibit the attendance at school for any and all purposes for any student with a "Life-Threatening Condition" who does not have medication or treatment orders and a nursing care plan on file at the school. A "Life-Threatening Condition" is defined as a health condition that will put the child in danger of death during the school day if medication or treatment orders and a nursing care plan are not in place. Students who are not in compliance with RCW 28A.210.320 are prohibited from attendance until such time that they come into complete compliance. Any parent/legal guardian who contests the schools decision has the right to due process procedures as found in Tumwater School District Policy 3200.</p> <p>Does your child have a life threatening condition? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epi-Pen prescribed <input type="checkbox"/> Yes <input type="checkbox"/> No Allergic to: _____</p> <p>Describe reaction: _____</p> <p>Date of last reaction: _____</p> <p>Does your child have severe asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No          i.e. ER visit/Hospital Stay/Oral Steroids/2 unplanned visits for asthma in the last year?</p> <p><input type="checkbox"/> Diabetes Type 1 <input type="checkbox"/> Bleeding Condition: Describe _____</p> <p><input type="checkbox"/> Seizures: <input type="checkbox"/> Current <input type="checkbox"/> History Type _____</p> <p><input type="checkbox"/> Cardiac: Describe _____</p>	<p><b>Health Information</b> <input type="checkbox"/> No Medical Conditions</p> <p><input type="checkbox"/> Allergies: Please list _____</p> <p>Describe mild reaction _____</p> <p><input type="checkbox"/> Asthma Triggers: <input type="checkbox"/> Resp. Infection <input type="checkbox"/> Exercise <input type="checkbox"/> Pollen <input type="checkbox"/> Molds <input type="checkbox"/> Smoke</p> <p><input type="checkbox"/> Strong odors/fumes <input type="checkbox"/> Weather/Temp Change <input type="checkbox"/> Food _____</p> <p><input type="checkbox"/> ADD/ADHD Dx by/year _____ <input type="checkbox"/> ASD Dx by/year _____</p> <p><input type="checkbox"/> Speech Condition <input type="checkbox"/> Glasses/Contacts <input type="checkbox"/> Hearing Aid(s) _____</p> <p><input type="checkbox"/> Feeding Support _____ <input type="checkbox"/> Mobility Support _____</p> <p><input type="checkbox"/> Other Health Conditions _____</p> <p>Medication(s) Currently Used: _____ Taken at: _____</p> <p><input type="checkbox"/> School <input type="checkbox"/> Home</p> <p><input type="checkbox"/> School <input type="checkbox"/> Home</p> <p><input type="checkbox"/> School <input type="checkbox"/> Home</p>
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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 forms or the form is available at TSD schools or online at the TSD website.

If your child is ill/injured at school, we will contact the parent/legal guardian or emergency contact person, if at all possible, and call 911, if the injury or illness warrants it. I consent to the release of medical information related to my child, to school personnel, as needed, to ensure his/her safety at school. I understand that it will be my responsibility to arrange for payment for medical care, should my child be ill/injured. I have read and understand this form.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_