**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name of Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: ◻ Male ◻ Female

Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

◻ No ◻ Yes G**lasses/Contacts** Eye Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last eye exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

◻ No ◻ Yes **Hearing aids** Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last hearing exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Provider: Dentist: Date of last visit dental visit:**

| Daily Medications State law RCW 28A.210.260requires written permission from a Health Care Provider and parent ***before*** any  medication (**prescription or over-the-counter**) can be given at school. A form is available in the school office. |
| --- |

◻ No ◻ Yes **Medication(s) needed at school** (list):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

◻ No ◻ Yes **Medication(s) taken at home** (list):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

◻ No ◻ Yes **Allergies** (medication):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| **Life Threatening Medical Conditions**  Washington State law requires that students with life-threatening health conditions, where the condition could “put the child in danger of death during the school day,” have medication/treatment orders and a nursing plan in place at school ***before*** your child can attend school. Please arrange to meet with the school nurse. |
| --- |

**Life Threatening Conditions (Requires Health Care Provider Orders)** please, check all that apply and explain:

◻ No ◻ Yes **Severe allergic reaction to nuts** (list):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

◻ No ◻ Yes **Severe allergic reaction to bee stings requiring emergency medication:**

◻ No ◻ Yes **Other severe allergies-affecting school:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

◻ No ◻ Yes **Severe** **asthma: regularly takes medication for asthmatic condition and/or hospitalized within the**

**last 5 years for asthmatic condition**

◻ No ◻ Yes **Diabetes**

◻ No ◻ Yes **Seizure disorder that requires an emergency medication:**

**Health Concerns: (**which maypotentially be a life threatening conditionsthat may require Health Care Provider orders)

Please check all that apply and explain:

◻ No ◻ Yes **Asthma: takes medication only when needed:**

◻ No ◻ Yes **Seizure: type of seizures and date of last seizure:**

◻ No ◻ Yes **Heart condition**:

◻ No ◻ Yes **Behavioral/emotional concerns (ADD/ADHD, anxiety, autism)**:

◻ No ◻ Yes  **Other health concerns**:

◻ No ◻ Yes  **Any other chronic or recurring illness:**

◻ No ◻ Yes  **History of concussion:**

**Does your child have any other condition that would affect his/her classroom performance or P.E. activities?**

◻ No ◻Yes If yes, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*All health information is considered confidential. It will be shared electronically with staff as needed during the time your child is enrolled in Brewster School District in order to ensure the health and safety of your child, unless otherwise requested by you in writing.*

**Parent/guardian signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_