

Student Health History & Emergency Medical Treatment Consent Form



Student Name: _____ School: _____
 Address: _____ Birth date: _____ Gender: _____
 Student's Doctor/Healthcare Provider: _____ Phone: _____

The Kelso School District requires that a parent/guardian complete a Student Health History Form. The district may use this information to advise families of the need for further medical attention, and to plan for potential health concerns during the school day.

NOTE: If your child has a life-threatening condition, such as severe bee sting or severe food allergies, asthma, diabetes, seizure, etc., they are required by Washington State Law to have a medication, treatment order and nursing plan in place BEFORE they can attend school. The medication and treatment order must be from the child's licensed health care provider and needs to be reviewed/renewed before the start of EACH school year in accordance with RCW 28A.210.320. The law defines life-threatening condition as a "health condition that will put the child in danger of death during the school day if a medication, treatment order and a nursing plan are not in place".

INDICATE IF STUDENT HAS BEEN DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER WITH ANY OF THE FOLLOWING:

HEALTH CONDITION	YES	NO	EXPLANATION
Medication Allergies			List:
Food Allergies			Food(s): Peanut___ Dairy___ Eggs___ Other:_____ Life Threatening: YES (requires Epi-pen at school)___ NO___
Allergy to Bee Stings			Life Threatening: YES (requires Epi-pen at school)___ NO___
Asthma (requires an IHP)			Last date inhaler was used:
Diabetes (requires an IHP)			Type 1:___ Insulin Injection:___ Insulin Pump:___ Type 2:___ Insulin Injection:___ Oral Medication___ Diet:___
Seizure Disorder (requires an IHP)			Type:_____ Date of last seizure:_____
Neurological Disorders			Specify:
Heart Condition			Specify:
Blood Disorder			Specify: Treatment:
Cancer			Specify: Treatment:
Bowel/Bladder Issues			Specify: Treatment:
Bone/Muscle Problems			Specify:
Scoliosis			Treatment:
ADD/ADHD			Medication: Needed at school YES___ NO___
Mental Health/Behavioral			Specify: Treatment:
Wears Glasses/Contacts			Glasses:___ Contacts:___
Hearing Loss			Right Ear:___ Left Ear:___
Other Health Concerns			Specify: Treatment:
Medication Taken at Home			List (if not listed above):

The information on this form may be shared confidentially with school staff and emergency responders as needed. In the event of a medical emergency with my child, I understand every effort will be made to inform me. If emergency care is needed, I authorize qualified professionals to provide assessment, diagnosis and any necessary emergency treatment. I understand that the school district assumes no financial liability for expenses incurred due to accident, injury and/or unforeseen circumstances.

By completing and signing this form you as the parent/guardian agree that you will be responsible for communicating ANY changes to this form with the school office and health specialist.

 PARENT/GUARDIAN SIGNATURE

 PRINTED NAME

 DATE

FOR OFFICE USE ONLY:

Reviewed by Health Specialist: _____ Date: _____ School Year: _____ Grade: _____ Grad Year: _____