Student Health History & Emergency Medical Treatment Consent Form

Student Name:_____ **School:**_____

Addresss:_____ **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 an Epi-pen at school) ☐ NO ☐
Allergy to Bee Stings			Life Threatening: YES (requires an Epi-pen at school) ☐ NO ☐
Allergies (other)			List: Epi-pen required: ☐ Other Medication needed:
Asthma			Last date inhaler was used:
Diabetes			Type 1: ☐ Insulin Injection: ☐ Insulin Pump: ☐
			Type 2: ☐ Insulin Injection: ☐ Oral Medication: ☐ Diet: ☐
Seizure Disorder			Type: Medications:
			Date of last seizure:
Neurological Disorders			Specify:
Heart Condtion			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/Behavorial			Specify: Treatment:
Wears Glasses/Contacts			Glasses: ☐ Contacts: ☐
Hearing Loss			Right ear: ☐ Left ear: ☐ Hearing aid(s):
Other Health Concerns			Specify:
Medication Taken at Home (if not already listed)			List:

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:_____

School Year:_____ ***Grade:***_____ ***Grad Year:***_____