STUDENT HEALTH REGISTRATION FORM & CONSENT FOR EMERGENCY MEDICAL TREATMENT

Student Name: _____ Date of Birth: _____ Grade: _____ Gender: _____
Physical address: _____
Mailing address (if different):_____

Mother's Name: _____ Cell Phone: _____ Email: _____
Father's mailing address (if different): _____
Father's Employer: _____ Work phone: _____

Father's Name: _____ Cell Phone: _____ Email: _____
Mother's mailing address (if different): _____
Mother's Employer: _____ Work phone: _____

Emergency Contact: _____ Relationship: _____Phone number: _____
Emergency Contact: _____ Relationship: _____Phone number: _____

Doctor: _____ Phone: _____ Dentist: _____ Phone: _____
Preferred Hospital: _____ Medical insurance: _____ Policy #: _____

PLEASE CIRCLE ANY LIFE-THREATENING CONDITIONS

State Law, RCW 28A.210 requires that students with life-threatening health conditions must have physician orders and a nursing care plan before attending school. This information may be shared with school district staff that have a "need to know," in order to provide a healthy, safe environment.

☐ NO KNOWN HEALTH CONCERNS	
RESPIRATORY PROBLEMS: Asthma, cystic fibrosis, etc.	Severity:
	Special needs/medications:
SEVERE ALLERGY TO: Food, insects, medication Life-threatening: ☐ Yes ☐ No	Allergen/ reaction:
	Medications needed:
SEIZURE DISORDER: Epilepsy etc.	Type:
	Special needs/medications:
A.D.D./ A.D.H.D (circle one)	Special needs/medications:
DIABETES	Type:
	Special needs/medications:
NEUROLOGICAL CONDITION: Hydrocephalus, cerebral palsy, etc.	Type:
	Medication needed:
HEART CONDITIONS	Type:
	Special needs:
ORTHOPEDIC PROBLEMS: Arthritis, scoliosis, braces, wheelchair	Type:
	Surgeries/limitations:
CANCER, LEUKEMIA, TUMORS	Type:
	Special needs/medications:
DIGESTIVE PROLEMS: Ulcers, colitis, etc.	Type:
	Special needs/medications:
URINARY/KIDNEY DISORDER	Type:
	Special needs/medications:
VISION/HEARING PROBLEMS OR COMPLETE LOSS OF	Type:
	Special needs/contacts/glasses/hearing aids
SERIOUS ILLNESS, INJURIES, OPERATIONS	Type:
	Special needs:
OTHER DIAGNOSED HEALTH PROBLEMS	Type:
	Special needs:

IF MEDICATIONS ARE NEEDED AT SCHOOL PLEASE CONTACT THE SCHOOL OFFICE FOR APPROPRIATE FORMS

I will keep the school health services informed throughout the year regarding any changes in health status and/or contact information. I understand that if either parent/guardian or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize the school staff to request emergency medical services (911). I understand I may be responsible for the payment of any medical services if needed.

Parent/guardian signature: _____ Date: _____