**Cashmere School District**

**District Nurse – Amber Varrelman, RN**

**509-782-2001 Fax 509-782-2547**

**STUDENT HEALTH INFORMATION**

*The information below is to help school staff understand any health concerns that might affect your child’s safety or education.*

**Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 *First Middle Last*

**Date of Birth**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Sex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Daytime Phone: #1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ #2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ #3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HISTORY** *Please mark if your child has any of the following health conditions*:

 \_\_\_\_ Asthma ❒ Will need inhaler at school ❒ Seen in hospital/Emergency Room in last five years for asthma?

 \_\_\_\_ Severe allergy requiring Epi-pen? What is your student allergic to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_ Diabetes ❒ requires insulin injection

 \_\_\_\_ Seizure disorder

 \_\_\_\_ Heart condition

 \_\_\_\_ ADD/ADHD ❒ Medicated

 \_\_\_\_ Other – please explain any health concerns you think we should know about at school:

 \_\_\_\_ Life threatening health condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child wear hearing aides? ❒Yes ❒No Does your child wear glasses/contacts? ❒Yes ❒No

**❒ My child has NO HEALTH PROBLEMS**

**LIFE-THREATENING CONDITIONS**

**\* If yes, a meeting with the school nurse is required. Washington State Law requires that medication or treatment orders and a health care plan be in place prior to starting school.**

**MEDICATION**

Does your child take any medication? ❒ No ❒ Yes, name of medication:

Reason for taking medication:

Will medication be needed at school? ❒ No ❒ Yes\*

**\* If your child needs medication at school, please contact the school for the “Medication Authorization” form. This form must be completed every year before any medication may be administered at school.**

**RCW28A.210 Sec. 1** requires all students with life threatening conditions to have both medical authorization and necessary medication at school BEFORE that student will be allowed to attend school. Medications that may be required under this law include, but are not limited to: meter-dose inhalers, Epi Pens, insulin, and medication for seizures.

I authorize and give my consent to the authorities of Cashmere School District to obtain emergency medical treatment. I also authorize medical authorities to perform upon or administer necessary emergency medical or surgical treatment to the above named student. District authorities are not excused from attempting to contact me before relying upon this authorization.

**AUTHORIZATION FOR SHARING HEALTH INFORMATION** I understand that the information given above may be shared with some school staff to provide for the health and safety of my child.

Parent/Guardian Print then Sign \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_