Bainbridge Island School District — Student Health Information

Student Name_____ **School**_____**Grade** _____ **Teacher**_____
Date of Birth _____ **Gender**: M / F / Other **Parent(s)/Guardian** _____ **Date**_____
Parent(s)/Guardian phone: _____

The information you provide about your student's health issues will be reviewed by the school nurse and may be shared with your student's teacher(s), principal, physical education, music and library specialists, the school secretaries, the school safety supervisors, and any other school personnel who are in regular contact with your student and have a need to know so that they are able to assist in protecting your student's health and safety at school. If you have any questions, please contact the school nurse.

Health Care Provider		Phone		☐ Please check here if NO INSURANCE
Dentist		Phone		
Health Insurance		Policy Number		

☐ **My child does not have any health conditions that will affect him/her at school.**
(If this box is checked, no further information is necessary. Please complete/sign/date* the bottom and return to school office).

☐ **I would like to discuss my child's health concerns with the School Nurse.**

SERIOUS HEALTH CONDITIONS:

Washington State Law requires that schools be prepared for a life-threatening event on the day the student starts school. This law requires that parents have Health Care Provider orders completed, prescription(s) filled, and all the necessary supplies and paperwork at school before the first day the child attends school. These forms are used to develop a Health Care/Section 504 Plan, and are required to be renewed on an annual basis at the beginning of each school year. To obtain these forms, contact the school office or visit the Health Services webpage: http://bisd303.org/Page/8815.

☐ My child has the following serious health condition(s) – Check boxes below:

- ☐ Allergy (life threatening – requires an epinephrine prescription such as Epi Pen or Auvi-Q).
  Allergens: _____ Date of last reaction: _____
- ☐ Asthma – Will your child require a rescue inhaler (such as Albuterol) at school? YES ☐ NO ☐
- ☐ Heart Condition: _____
- ☐ Diabetes: Date of diagnosis: _____
  ☐ Insulin Pump ☐ Insulin Pen ☐ Insulin via syringe
- ☐ Seizure Disorder: Date of diagnosis: _____ Date of last seizure: _____
  Type:_____ Rescue Medication? YES ☐ NO ☐ _____

OTHER HEALTH CONDITIONS (check appropriate box below):

- ☐ History of recent Concussion (diagnosed by a licensed health care provider within the last 12 months) – Date of concussion: _____
- ☐ Hearing concerns – ☐ Does your child wear hearing aids? ☐ Does your child have a known hearing loss?_____
- ☐ Vision concerns – ☐ Glasses ☐ Contacts ☐ Other: _____
- ☐ Mental Health Conditions:_____
- ☐ Other medical conditions/concerns or non life-threatening allergies (medications, food, etc.), please explain:_____

_____

_____

MEDICATIONS: Prescription, supplements, over-the-counter (eye drops, ointments, etc):

Does your child require medication at school on a regular or as needed basis? **YES** ☐ **NO** ☐ _____
If Yes, BISD requires a Medication at School form (found at http://bisd303.org/Page/3442) to be signed by BOTH parent and a licensed practitioner for medication to be administered at school.

CONSENT for Health Care/Section 504 Plan: I give consent to the disclosure of the information provided on this form, as well as forms for serious or life-threatening health conditions (if noted above), so that the individuals designated on these forms may assess my child's need for a Health Care/Section 504 Plan. I give permission for my child's school to update my child's Certificate of Immunization Status (CIS) form.

Written Notice for Health Care/Section 504 Plan: The purpose of this written notice is to inform you that the District is proposing to assess your child's need for Health Care/Section 504 Plan based on the information you have provided on this form and to your child's school. A copy of Your Rights Under Section 504 can be found at http://bisd303.org/Page/499. If you have additional questions, please contact the school nurse.

FIRST AID/EMERGENCY SERVICES/MEDICAL/HEALTH INFORMATION: *If a parent cannot be reached at the time of an emergency, I give permission for school staff to administer and/or arrange for necessary First Aid/medical care. In case of an emergency, your child will be taken to the nearest hospital for treatment and you will be notified immediately. Health information may be disclosed in the event that your child requires emergency treatment. {OUTDOOR ED: Medical/health information may also be shared with the director of the facility where the outdoor education program is being held and parent volunteers with first aid training or a medical background.}*

Parent/Guardian Name (print): _____

*Signature: _____ Date: _____ Rev.01/18