Columbia 206 SCHOOL DISTRICT 2023/2024 School year
HEALTH INFORMATION AND EMERGENCY MEDICAL CONTACT

Name ____ Birthdate ______________ Grade ________
Last First MI Legal name (if different)

Address ____ Home Phone ______________________
Street City State Zip code

Is this a new address and/or phone number? ☐ Yes ☐ No Gender: ☐ Male ☐ Female ☐ other______________________

Student lives with: ☐ Both parents ☐ Mother only ☐ Father only ☐ Mother & stepfather ☐ Father & stepmother
☐ Agency ☐ Self ☐ Legal guardian ☐ Other ______________________

Parent/Guardian 1 name ______________________ Parent/Guardian 2 name ______________________

Parent/Guardian 1 phone ______________________ Parent/Guardian 2 phone ______________________

Parent/Guardian 1 phone ______________________ Parent/Guardian 2 cell phone ______________________

Emergency contact ______________________ Phone ______________
Name Relationship to child

Emergency contact ______________________ Phone ______________
Name Relationship to child

Licensed Healthcare Provider (LHP) ______________________ Phone ______________

Dentist ______________________ Phone ______________

Dear Parent/Guardian: Please describe your child's current health status in detail below. Keep the school updated regarding any changes in health or medication status which impacts your child. If your child needs to take medication at school, please notify the school nurse, this can include overnight field trips or sporting events after school hours.

☐ No health problems to my knowledge.

Current Health History:

Please answer by checking	**No**	**Yes**	**Mild**	**Moderate**	**Severe**		
Does your child have vision problems?	☐	☐	☐	☐	☐	☐ Contacts	☐ Glasses
Does your child have hearing problems?	☐	☐	☐	☐	☐	☐ Hearing aid(s)	

Check if your child has any of the following:	**No**	**Yes**	**Mild**	**Moderate**	**Severe**
Allergy – food (type) ______________	☐	☐	☐	☐	☐
Allergy – insect (type) ______________	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Diabetes (type) ______________	☐	☐	☐	☐	☐
Cardiac Condition (type) ______________	☐	☐	☐	☐	☐
Bleeding Disorder (type) ______________	☐	☐	☐	☐	☐
Seizures (type) ______________	☐	☐	☐	☐	☐

Explain if other issues exist (including learning disabilities) ______________________
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IF ANY OF THE ABOVE HEALTH CONDITIONS ARE LIFE-THREATENING, RCW 28A.210.320 requires that licensed healthcare provider (LHP) orders, medications, and/or treatments and a nursing care plan must be in place before a student attends school.

Does your child need medication while at school or after-school functions? ☐ Yes* ☐ No If yes, explain ______________________
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Does your child take medications of any kind, anywhere? ☐ Yes* ☐ No If yes, explain______________________
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Has your child had any serious injuries that impact school? ☐ Yes* ☐ No If yes, explain______________________
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The school nurse must sometimes share health information with school staff. If you have concerns about sharing this information, please contact the school nurse.

***Students requiring medication (<u>prescription or non-prescription</u>) at school MUST have a written order by a LHP and written parent consent. These forms are available at every building from the secretaries and the school nurse.**
I authorize ______________ School District staff to contact a LHP/dentist or 911 if necessary, and I further authorize those contacted to initiate necessary treatment for emergency care, including transportation to the hospital. I understand that ______________ School District, its employees, and Board of Directors assume no liability of any nature in relationship to transporting or treatment of said minor.
I permit the school to add information to the Washington State Immunization Information System to help maintain my child's record.
I agree to inform the school nurse of any changes in your child's health that may occur throughout the school year.

Parent/Guardian Signature ______________________________ Date ______________________