

Toutle Lake School District #112
5050 Spirit Lake Highway
Toutle, WA 98649
Phone (360) 274-6182 / Fax (360) 274-7608

Student Health History for _____ School Year
To be completed each year by Parent/Guardian

Name of Student: _____ Date of Birth: ____/____/____ Male Female
Parent Contact: Name _____ Phone # _____ Teacher _____ Grade _____
Health Care Provider: _____ Phone # _____ Preferred Hospital: _____

DOES YOUR CHILD HAVE A MEDICALLY DIAGNOSED LIFE-THREATENING HEALTH CONDITION? Yes No

If YES, please check the category that best represents your child's diagnosed medical condition:

Asthma Seizure Allergy Diabetes Other _____

If a life threatening health condition exists, a medication/treatment order from a licensed health professional **must** be provided to your student's school prior to his/her attendance, in accordance with RCW 28A.210.320 and TLSLSD Policy 3413. An Authorization for Administration of Medication Form is available from the school office or on the district website. If a health condition exists, an Emergency Care Plan **must** be developed by the school Nurse.

**YOUR CHILD WILL NOT BE ALLOWED TO ATTEND SCHOOL UNTIL ALL REQUIRED PAPERWORK IS PROVIDED.
IT IS THE PARENT/GUARDIAN RESPONSIBILITY TO SECURE ALL NECESSARY SIGNATURES AND INFORMATION.**

If you checked NO above, does your child have a health concern that would affect his/her classroom performance or P.E. activities? Yes No

If yes, explain: _____

Yes No Behavioral/Emotional Concerns: _____

Yes No Attention Deficit Disorder (Specify): ADD ADHD Medication: _____

Yes No Orthopedic Condition: _____

Yes No Glasses/Contacts; date of last eye evaluation: _____

Yes No Hearing Impaired; date of last hearing exam: _____

MEDICATIONS

Prior to any medication give at school, a written authorization is required from a Licensed Health Professional and parent/legal guardian, in accordance with RCW 28A.210.260 and TLSLSD Policy 3416. **No medication will be administered until all required paperwork is provided.**

Yes No Medication needed at school (Specify): _____

Yes No Medication needed at home (Specify): _____

Name of Student: _____

HEALTH INSURANCE

Does your student have health insurance? Yes No

If you answer "no" or do not respond, health insurance information will be provided.

Office use only:
WA State Health Insurance information
was provided to parent.

_____ (initials)

I understand that the information above will be shared in a confidential manner with appropriate school staff that needs to know in order to provide for the health and safety of my student. I will keep the school informed throughout the year regarding any changes in health status and/or contact information. If parents/legal guardians or authorized emergency contacts cannot be reached at the time of a medical emergency, and if immediate care is urgent in the judgment of school authorities, I authorize and direct the school authority to request emergency medical services (911). I understand I will assume full responsibility for the payment of any services rendered.

May the above mentioned student receive blood products in case of emergency? Yes No

Parent/Guardian signature: _____ Date: _____

FOR OFFICIAL USE ONLY

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|------------------------------|------------------------------|---|-------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> N/A | All paperwork for life threatening medical condition is complete. | _____ Init. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> N/A | All paperwork for the administration of medication at school is complete. | _____ Init. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> N/A | A level _____ health plan is in place. | _____ Init. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> N/A | Information is entered into Skyward. | _____ Init. |