

Columbia School District No. 206

STUDENT HEALTH HISTORY/EMERGENCY MEDICAL AUTHORIZATION

2010-2011

We would appreciate your help in updating your child's health and emergency information so that we can take the best possible care of him/her at school. **Please complete this information and return to school on or before the first day of school. Thank you!**

Child's Name _____ Sex _____ Birthdate _____ Grade _____
Address _____ Home Phone _____
Mother's Name _____ Work Phone _____ Cell Phone _____
Father's Name _____ Work Phone _____ Cell Phone _____
Child's Physician _____ Physician Phone _____
In case of emergency, call 1) _____ Phone _____
2) _____ Phone _____

Please check any of the spaces below which describes a health problem your child has which might require attention at school. If your child has no such health problems, check "No Health Problems."

NO HEALTH PROBLEMS

<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart condition	<input type="checkbox"/> Bladder or bowel problems
<input type="checkbox"/> Diabetes **	<input type="checkbox"/> Autism/Aspergers (circle one)	<input type="checkbox"/> Cancer/Leukemia
<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> ADD/ADHD (circle one)
<input type="checkbox"/> Vision problem/glasses	<input type="checkbox"/> Severe Headaches	<input type="checkbox"/> Depression or anxiety (circle one)
<input type="checkbox"/> Hearing problem	<input type="checkbox"/> Bleeding disorder – Explain _____	
<input type="checkbox"/> Seasonal Allergies/Hayfever	<input type="checkbox"/> Other – Explain _____	

****Allergic reaction (requiring medication) to:** Bee sting _____ Food (list) _____
Medications (list) _____ **Animals** _____ **Plants** _____
Other _____

Explain the allergic reaction and treatment: _____

**** SEE THE REVERSE SIDE OF THIS FORM IF YOUR STUDENT HAS AN ANAPHYLACTIC REACTION TO AN ALLERGY ****

Does your child take medication for any health concerns? Yes _____ No _____
If so, what is the name of the medication? _____

Will medication need to be taken during school hours? Yes _____ No _____
If so, what is the name of the medication? _____

To protect the safety of your child, school law **requires** that an Authorization for Administration of Medication at School be filled out and signed by the student's parent/guardian and attending Licensed Health Care Provider. This form **must** be completed for over-the-counter (OTC) and prescribed oral medications, Epi-pens and inhalers at school. **This form must be updated annually.**

I certify that the above information is correct. I give permission for the Columbia School District to forward health information on a need-to-know basis. This allows the district to alert staff about health concerns and to give records to EMS in case of an emergency. **I give permission for the hospital/health care provider to give medical treatment to my child.**

Parent/Guardian Signature _____ Date _____

Note: Please notify the school of any medical changes that will affect your child's safety at school.

This form needs to be updated every school year.

*** * * * LIFE-THREATENING CONDITIONS * * * ***

State law requires that a student who has a life-threatening condition have a medication and treatment order from a physician, medications, equipment and an emergency care plan (ECP) in place before the student attends school (RCW 28A.210, Section 1). The types of medications/health conditions under this law include, but are not limited to: meter-dose inhalers for asthma, Epi-pens for severe allergies, medications for uncontrolled seizures, and diabetes.

This law means that you must have the physician's medication and treatment order completed, medication, supplies, paperwork at school, and an emergency care plan prepared by the school nurse before the first day the child attends school.

*** * * * ANAPHYLAXIS * * * ***

If your child has an anaphylactic allergy, please answer the following questions:

1. What does your child have an anaphylactic allergic reaction to?
2. Describe your child's symptoms that occur with this allergic reaction.
3. When was your child's last severe allergic reaction?
4. What treatment or medication has your physician recommended?
5. Has your child been prescribed epinephrine or an Epi-pen?
6. What precautions does your child take to avoid the things that cause severe allergic reactions?

Please refer to the requirements stated above in the LIFE-THREATENING CONDITIONS, if your child has been prescribed an Epi-pen.

*** * * * DIABETES * * * ***

Requirements for Life-Threatening Conditions apply as well as specific requirements for accommodating students with diabetes. Please contact the school nurse to help with your child's individual health care plan. Parents of a diabetic child must designate an adult to provide care for their child at school according to state law and School Policy No. 3415. The school nurse is not responsible for the training or supervision of procedures authorized by the parents and carried out by the parent designated adult.