STUDENT HEALTH FORM 2022-2023

This information is considered confidential. To ensure the health and safety of your child, it will be shared with school staff as needed while your child is enrolled at Saint Rose of Lima Catholic School, unless you request otherwise in writing.

Student Name: ____

Grade: ________________ **Date of Birth:** ________________ ☐ **Male** ☐ **Female**

Life Threatening Medical Conditions: WA State law **(per RCW.28A.210.320)** requires a medication/treatment order from a Healthcare Provi child's health condition will put your child in danger during the school day. Written orders must be received by the school with a care plan a medications **BEFORE YOUR CHILD CAN ATTEND SCHOOL.**
Does your child have a **LIFE-THREATENING CONDITION**? ☐ NO ☐ YES
If yes, please specify the condition:

☐ NO ☐ YES Severe allergic reaction to bee sting? Please describe reaction:
Anaphylactic? ☐ No ☐ Yes

☐ NO ☐ YES Severe allergic reaction to **food** or **nuts**? Type:
Anaphylactic? ☐ No ☐ Yes

☐ NO ☐ YES Mild allergic reaction to **food** or **nuts** or **other**? Type:
Please describe reaction:

☐ NO ☐ YES Asthma? Will your child require asthma management during school hours? ☐ No ☐ Yes

☐ NO ☐ YES Diabetes? Type: ________________ Self Manage: ☐ No ☐ Yes Pump? ☐ No ☐ Yes

☐ NO ☐ YES Heart Condition? Diagnosis: ____

☐ NO ☐ YES Bleeding Disorder? Diagnosis: ____

☐ NO ☐ YES Seizure/Neurological Disorder? Please describe: ___________________________________

☐ NO ☐ YES GI/Feeding Condition? Please describe: ____

☐ NO ☐ YES Bowel/Bladder Condition? Please describe: _______________________________________

☐ NO ☐ YES Other Health Concerns: ____

☐ NO ☐ YES Does your child have any other condition that would affect classroom performance or PE activities? Please describe: ____

☐ NO ☐ YES Behavioral/Emotional Concerns: ____

☐ NO ☐ YES Visual Impairment? ☐ Glasses ☐ Contacts Date of last eye exam: _______________

☐ NO ☐ YES Hearing Impairment? Hearing Aids ☐ Yes Date of last hearing exam: ______________

Primary Care Provider: ____ **Date of Last Exam:** ___________

Dentist: ____ **Last Dental Exam:** ____________

Daily Medications

State law requires written authorization from a Health Care Provider and parent before any medication, prescription or over the counter, can be given at school. Please complete the medication administration form for any medications to be given at school.

Parent/Guardian Contact Phone Numbers: Please order from 1-3 priority calling order.

1.		*2.*		3.	

Parent/Guardian (Printed Name): ____

Parent/Guardian (Signature): ______________________________________**Date:** ________________