2008-09

Methow Valley School District

Methow Valley Elementary School 509.996.2186 / fax 509.996.9202
Liberty Bell High School 509.996.2215 / fax 509.996.3609

STUDENT HEALTH INFORMATION

The information below is to help school staff understand any health concerns that might affect your child's safety or learning.

Student's Name: _____ _____ _____
First *Middle* *Last*
Date of Birth: _____ **Sex:** _____ **Grade:** _____

MEDICAL HISTORY *Please mark if your child has any of the following health conditions*:
____ Asthma ❒ Will need inhaler at school ❒ Seen in hospital/Emergency Room in last five years for asthma
____ Severe allergy requiring Epi-pen? Allergy to: ❒ Food ❒ Bees/insects ❒ Plants ❒ Animals ❒ Drugs
____ Diabetes ❒ requires insulin injection
____ Seizure disorder
____ Heart condition
____ Frequent or severe headache
____ Behavior or emotional concerns
____ ADD/ADHD
____ Other - please explain any health concerns you think we should know about at school:
Does your child wear hearing aides? ❒Yes ❒No Does your child wear glasses/contacts? ❒Yes ❒No

Do any of the above condition(s) limit/effect your child at school? ❒ No ❒ Yes, explain:

❒ **My child has NO HEALTH PROBLEMS**

LIFE-THREATENING CONDITIONS
Does your child have a life-threatening health condition? ❒ No ❒ Yes ***** Describe:

*** If yes, a meeting with the school nurse is required. Washington State Law requires that medication or treatment orders and a health care plan be in place prior to starting school.**

MEDICATION
Does your child take any medication? ❒ No ❒ Yes, name of medication:

Reason for taking medication:

Will medication be needed at school? ❒ No ❒ Yes*
*** If your child needs medication at school, please contact the school for the "Medication Authorization" form. This form must be completed every year before any medication may be administered at school.**

MEDICAL
Does your child have a health care provider? ❒ Yes ❒ No
Name of child's health care provider _____phone number _____

DENTAL
Does your child have a dentist? ❒ Yes ❒ No
Name of child's dentist _____ phone number _____

INSURANCE
Does your child have medical insurance coverage? ❒ Yes ❒ No ❒ Don't know
Does your child have dental insurance coverage? ❒ Yes ❒ No ❒ Don't know
Would you like assistance finding insurance for your child? ❒ Yes

AUTHORIZATION FOR SHARING HEALTH INFORMATION I understand that the information given above may be shared with some school staff to provide for the health and safety of my child.

Parent/Guardian Signature _____ Date _____