Mead School District
HEALTH INFORMATION AND EMERGENCY MEDICAL TREATMENT

Child's Name_____ Legal Name_____ Birth Date_____
Last First M.I. (If Different)

Address_____ Zip_____ Phone_____ Grade_____ Teacher_____

Living With: (Circle One) Both Parents Mother Only Father Only Self Agency Legal Guardian Other_____

Father/Mother/Guardian Name_____ Best Phone_____ E-Mail_____
(Circle One)

Father/Mother/Guardian Name_____ Best Phone_____ E-Mail_____
(Circle One)

PLEASE CIRCLE ANY LIFE-THREATENING CONDITIONS

RCW 28A.210 requires that students with life-threatening conditions must have physician orders and a nursing care plan before attending school. This information may be shared with school district staff that have a "need to know," in order to provide a healthy, safe environment.

NO KNOWN HEALTH CONCERNS ☐	
HEART PROBLEM	Type: Special Needs:
DIABETES	Medication: Special Needs:
SEIZURE DISORDER - Epilepsy, etc.	Type: Special Needs/Medication:
NEUROLOGICAL PROBLEM Hydrocephalus, cerebral palsy, etc.	Type: Special Needs/Medication:
A.D.D./A.D.H.D.	Special Needs/Medication:
SEVERE ALLERGIES TO: Foods, Insects, medication, etc. Life Threatening? ☐ YES ☐ NO	Type & Reaction: Medication Needed:
RESPIRATORY PROBLEM Asthma, Cystic Fibrosis, etc.	Severity: Special Needs/Medication:
ORTHOPEDIC PROBLEM Arthritis, Scoliosis, Braces, Wheelchair	Type: Surgeries/Limitations:
CANCER, LEUKEMIA, TUMORS	Type: Special Needs/Medication:
DIGESTIVE PROBLEMS - Ulcer, Colitis, etc.	Type: Special Needs/Medication:
URINARY, KIDNEY DISORDER - Nephritis, etc.	Type: Special Needs/Medication:
VISION PROBLEM OR COMPLETE LOSS	Type: Special Needs/Corrections:
HEARING PROBLEM OR COMPLETE LOSS	Describe: Special Needs:
SERIOUS ILLNESSES, INJURIES, OPERATIONS	Describe/Dates: Special Needs:
OTHER DIAGNOSED HEALTH PROBLEMS	Describe: Special Needs/Medication:

NOTE: If medication is needed at school, please ask the school office for the appropriate forms.

Emergency contact person other than parent to be called if parent cannot be reached:

Name: _____ Phone:_____ Alt Phone:_____ Relationship_____

Name: _____ Phone:_____ Alt Phone:_____ Relationship_____

Dr._____ Phone_____ Dentist_____ Phone_____

I authorize school staff to contact my child's health care provider and/or 911 to procure emergency treatment for my child, including transportation to the nearest medical emergency facility.
I agree to inform the school of any changes in my child's health care information.

Parent/Legal Guardian Signature:_____ Date: _____

Form reviewed by School Nurse for health concerns: _____ (initials)