

**2018-2019 MEDICAL LAKE SCHOOL DISTRICT
ANNUAL HEALTH RECORD UPDATE / EMERGENCY CONTACT**

Student Name _____ Birthdate _____ Grade _____
Last First MI (Legal name if different)

Primary Family
 Guardian 1 Last Name _____ Guardian 1 First Name _____ Relationship to student _____
 Guardian 2 Last Name _____ Guardian 2 First Name _____ Relationship to student _____
 Address _____ Home Phone _____
 Mailing Address if different than above _____ Email _____

Student lives with: Both parents Mother only Father only Mother & stepfather Father & stepmother
 Agency Self Legal guardian Other _____

Secondary Family:
 Guardian 1 Last Name _____ Guardian 1 First Name _____ Relationship to student _____
 Guardian 2 Last Name _____ Guardian 2 First Name _____ Relationship to student _____
 Address _____ Home Phone _____
 Mailing Address if different than above _____ Email _____

Father's work phone _____ Mother's work phone _____
 Father's cell phone _____ Mother's cell phone _____
 Emergency contact _____ Phone _____
Name Relationship to child
 Emergency contact _____ Phone _____
Name Relationship to child
 Doctor _____ Phone _____ Dentist _____ Phone _____

Dear Parent: Please describe your child's health concerns in detail below. It is important that you keep the school informed of any changes in health or medication which would affect your child's performance. If your child needs to take medication at school, please notify the school nurse. This includes overnight field trips or sporting events that may extend past normal school hours.

No health problems to my knowledge.

Current Health History:

Please answer by checking

	No	Yes	Mild	Moderate	Severe		
Does your child have vision problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Contacts	<input type="checkbox"/> Glasses
Does your child have hearing problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hearing aid	

Check if your child has any of the following:

	No	Yes	Mild	Moderate	Severe
Allergy – food (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy – food (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy – insect (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma medication	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart problem (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explain if other issues exist (including learning disabilities)

IF ANY OF THE ABOVE HEALTH CONDITIONS ARE LIFE-THREATENING, RCW 28A.210 requires that physician orders, medications, and/or treatments and a nursing care plan must be in place before a student attends school.

BACK SIDE OF FORM MUST BE COMPLETED AND SIGNED BY PARENT OR GUARDIAN

Does your child need medication while at school or after-school functions? Yes* No If yes, explain

Does your child take medications of any kind? Yes* No If yes, explain

Has your child had any serious injuries? Yes* No If yes, explain

The school nurse must sometimes share health information with school staff. If you have concerns about sharing this information, please contact the school nurse.

***Students requiring medication (prescription or non-prescription) at school MUST have a written order by a Licensed Health Care Professional and written parent consent. These forms are available at every building from the secretaries and the school nurse.**

Insurance coverage is mandatory for participation in any school activity. Our district's insurance coverage does not provide medical insurance coverage for school accidents. This means you are responsible for the medical bills if your child is hurt during school or school activities. The school's liability coverage will provide protection if the district is found to be negligent in some manner; however, a slip or fall is rarely the fault of the school district. A brochure outlining student insurance is available from the main office.

Choose one:

Please send home a brochure on the insurance program.

We have personal medical insurance and our insurance carrier is _____
Name of your insurance company is required.

We do not have insurance and we decline to enroll in the school's insurance program.

I authorize Medical Lake School District staff to contact a doctor/dentist or 911 if necessary, and I further authorize those contacted to initiate necessary treatment for emergency care, including transportation to the hospital, at my expense. I understand that Medical Lake School District, its employees, and Board of Directors assume no liability of any nature in relationship to transporting or treatment of said minor.

***IT IS VERY IMPORTANT THAT YOU INFORM THE SCHOOL NURSE OF ANY CHANGES IN YOUR CHILD'S HEALTH THAT MAY OCCUR THROUGHOUT THE SCHOOL YEAR.**

Parent/Guardian Signature _____ Date _____