2019-2020
Required Student Health Registration Form and Annual Update

Name: ____ Birthdate: ____________
Last First M.I. (Legal Name if Different)

Address: ____ Home Phone: ____________
Street City State Zip Code

Student Lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Mother & Stepfather ☐ Father & Stepmother
☐ Agency ☐ Self ☐ Legal Guardian ☐ Other: ____________

Is this a new address and/or phone number? ☐ Yes ☐ No Gender: ________ Grade: ________

Father's Name: ____________ Mother's Name: ____________

Father's Cell Phone: ____________ Mother's Cell Phone: ____________

Father's Work Phone: ____________ Mother's Work Phone: ____________

Emergency Contact: ____
Name Relationship to child Phone

Emergency Contact: ____
Name Relationship to child Phone

Doctor: ____________ Phone: ____________ Dentist: ____________ Phone: ____________

Current Health History: (Please answer by checking)

☐ **No health problems to my knowledge**

	Yes	Mild	Moderate	Severe
Allergy: ____________ **Medication:** ____________	☐	☐	☐	☐
Food intolerance: ____________	☐	☐	☐	☐
Asthma: ____________	☐	☐	☐	☐
Diabetes: ____________	☐	☐	☐	☐
Cardiac condition: ____________	☐	☐	☐	☐
Seizure disorder: ____________	☐	☐	☐	☐
Bleeding disorder: ____________	☐	☐	☐	☐
Other: ____________	☐	☐	☐	☐

Does student have vision problem? ☐ **Yes** Contacts: ☐ Glasses: ☐
Does student have hearing problem? ☐ **Yes** Hearing aid: ☐

For students with life threatening health conditions, RCW 28A.210.320, requires that a licensed health care provider (LHP) order, medication and a nursing care plan be in place before the student attends school.

MEDICATION (prescription or non-prescription):
Does your child take any medication? ☐ **Yes** ☐ **No** Name of medication: ____________
Purpose: ____________
Will medication be needed at school? ☐ **Yes*** ☐ **No**
*If your child needs to take medication at school, please contact the school office for the necessary authorization form. This form must be completed prior to the administration of any medication at school.

I understand that the information given above may be shared with appropriate school staff to provide for the health and safety of my child. I authorize Cheney School District (CSD) staff to contact health care professionals, including 911, if necessary and I further authorize those contacted to initiate necessary treatment for emergency care, including transportation to the hospital or clinic at my expense. I understand that CSD, 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

In accordance with Cheney School District Policy No. 3414

Form No. 663A, Rev. 1/19 Form to be used with registration packets and for annual updates

____
School nurse reviewed/initials