

Office Use Only
 Reviewed by: _____
 School Nurse/Date _____

This information is needed to keep your child healthy and safe while at school. If your child has a life threatening health condition, it is the parent/guardian's responsibility to notify the school nurse PRIOR to school beginning so that an appropriate plan of care is developed. Both page 1 and page 2 are to be carefully completed by the parent/guardian and returned to the school office with your completed registration packet.

Student Name: _____ Birthday: _____ M or F 2010/11 Grade: _____

Address: _____ Home Phone: _____

Father: _____ Workplace: _____ Work Ph: _____ Cell/Pager: _____

Mother: _____ Workplace: _____ Work Ph: _____ Cell/Pager: _____

Emergency Contact #1: _____ Phone: _____

Emergency Contact #2: _____ Phone: _____

HAS YOUR CHILD BEEN DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER WITH ANY OF THE FOLLOWING? Check yes or no and explain all "yes" answers.

	YES	NO	EXPLANATION
Allergies (drugs, food, latex, insects)			
Attention Deficit Disorder			
Attention Deficit Hyperactivity Disorder			
Asthma			
Autism/Asperger's Syndrome			
Bladder/Bowel Concerns			
Blood Disorder			
Cancer			
Cerebral Palsy			
Depression			
Diabetes			
Ear or Hearing Concerns			
Eating Disorder			
Emotional or Psychological Concerns			
Eye or Vision Concerns			
Heart Problems			
Migraine or Severe Headaches			
Orthopedic Conditions			
Seizures			
Skin Concerns			
Spina Bifida			
Other			

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Student's Name: _____ 2010/11 Grade: _____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING? Check yes or no and explain all "yes" answers.

	YES	NO	EXPLANATION
Serious illness			
Serious injury			
Surgery			
Hospitalization			

DOES YOUR CHILD? Check yes or no and explain all "yes" answers.

	YES	NO	EXPLANATION
Wear glasses			for distance <input type="checkbox"/> for reading <input type="checkbox"/>
Wear contacts			for distance <input type="checkbox"/> for reading <input type="checkbox"/>
Wear hearing aids			left ear <input type="checkbox"/> right ear <input type="checkbox"/>
Have ear ventilation tubes			
Use special medical equipment			
Require special medical procedures/treatments at school <input type="checkbox"/> and/or at home <input type="checkbox"/>			
Have any physical or medical limitations			
Have a condition that prevents full participation in PE			

Washington State law requires written authorization from a licensed healthcare provider and parent before any medication (prescription or over-the-counter) may be taken at school. A form is available from the school nurse.

MEDICATION: Check yes or no and explain all "yes" answers.

	YES	NO	MEDICATION
Is medication needed at home?			
Is medication needed at school?			

 Name of Physician/Licensed Healthcare Provider Phone

 Name of Other Specialist Phone

Date of last well-child exam: _____ Preferred hospital in case of an emergency: _____

If you would like more information regarding any health issue concerning your child, please feel free to contact the school nurse.

I understand that the information above will be shared in a confidential manner with appropriate school staff who need to know in order to provide for the health and safety of my student. I will keep the school informed throughout the year regarding any changes in health status and/or contact information. If parents/guardians or authorized emergency contacts cannot be reached at the time of a medical emergency, and if immediate care is urgent in the judgment of school authorities, I authorize and direct the school authorities to request emergency medical services (911). I understand that I may be responsible for the payment of any services rendered.

Parent Signature: _____ Date: _____