PINNACLES PREP

Student Health Information Form Entered____

Legal Last Name of Student	Legal First Name	☐ Male ☐ Female (Please circle)	Grade	Date of Birth

Please complete sections 1, 2, and 3, date and sign this form, and return to the school office. Please keep the school informed of changes in your child's health or medication during the school year.

Section 1 Health Conditions **Please place an ✕ on all health conditions which apply to your student.**

☐ ***My child has no known health problems***

Please indicate below ALL CURRENT ACTIVE health conditions which MAY IMPACT YOUR STUDENT AT SCHOOL:

Significant Allergies likely to affect student at school:

- ☐ Bee/Insect - More than swelling (AB)
- ☐ Environmental Allergy-List _____(AE)
- ☐ Food Allergy - List _____(AF)
- ☐ Medication Allergies _____ (ADR)
- ☐ Other Significant Allergies-List_____(AO)
- ☐ Epi Pen needed for Allergy above (AEP)
- ☐ Diabetes (Insulin dependent) (D)
- ☐ Seizures (S)
  Medication ☐ Yes ☐ No (SM)
- ☐ Asthma ☐ Exercise-induced? (R) (RA)
  ☐ Inhaler needed at School? (RIS)
  (requires doctor's order)

- ☐ Heart Condition (describe):_____ (HC)
  Activity Restrictions ☐ Yes ☐ No (HCR)
- ☐ Wear Glasses / Contacts (VG)
- ☐ Known Hearing Loss (H)
- ☐ ADD/ADHD-Medication _____ (ADH)
- ☐ Autism ☐ Asperger's Syndrome (NC) (NA)
- ☐ Mental Health (please specify) (PJ)
- ☐ Headaches / Migraines (NH)
- ☐ Other Significant Health Issues (Please describe):

- ☐ Request call from School nurse

Section 2 Life-Threatening Information

Are any of the above checked conditions life-threatening? ☐ **Yes** ☐ **No**

As parent/guardian, I agree to contact the school nurse to create an individualized health care plan for my child with a life threatening condition. State law requires all students with life threatening conditions to have both medical authorization and necessary medication at school before that student will be allowed to attend school. Medications that may be required under this law include, but are not limited to: meter-dose inhalers, Epi-pens, Insulin, and medication for seizures (per RCW 28A.210 Sec.1).

Section 3 Medication Information

For school staff to administer or store any prescription or over-the-counter medication, an *Authorization for Medication Administration* (AMA) must be signed by a parent/guardian and the physician, and must be on file in the school office. **A new AMA form is required at the beginning of each school year, or whenever there has been a change in medication or dose. For students who carry and self-administer emergency rescue medications we strongly encourage parents to provide a backup rescue medication to store at the school office. A completed AMA form is required to store medications at school.** *The Authorization for Medication Administration* dmpk gq available at your child's school**.**

Parents and guardians may wish to share information about medications their child may take while at home, which may influence how their child learns at school. **If you would like to share this information, please list any medications your child takes while at home:**

Consent: I authorize and give my consent to the authorities of Ngl _ajcq Npcn Af _pcpQaf mmj to obtain emergency medical treatment. I also authorize medical authorities to perform upon or administer necessary emergency medical or surgical treatment to the above named student. District authorities are not excused from attempting to contact me before relying upon this authorization. I also authorize that the information listed above may be shared with school personnel on a need-to-know basis to facilitate the school district in providing a safe environment for my child. **If there are any health changes to the above listed information, it will be the parent/guardian's responsibility to inform the school on the yearly update student information form.**

Signature of Parent/Guardian_____ **Relationship to Student** _____ **Date**_____