

STUDENT HEALTH INVENTORY

Information on this form **required** to be filled out (updated) for each new school year.

For office use only
Reviewed by:

Student Name: _____ Birthdate: _____
Legal Name: First Middle Last

School: _____ Grade: _____ School Year: _____

HEALTH INFORMATION

Does your student have any of the following LIFE-THREATENING HEALTH CONDITIONS?

- Asthma** requiring rescue inhaler at school? If needed, please answer the following questions:
Triggers: _____
Rescue inhaler used in the **past year**? Yes No Date inhaler last used: _____
Has your student ever needed to go to the Emergency Room for Asthma? Yes No
- Allergy/Anaphylaxis** requiring Epi-Pen at school? Triggers/Allergens: _____
- Diabetes** My student has: Insulin Pump Insulin Pen Insulin Injection
- Seizure disorder** Emergency medication required at school? Yes No Name of medication: _____
- Other life-threatening conditions** requiring **immediate** assistance and/or medication at school—please explain: _____



IMPORTANT—Any box checked above will **require** a meeting with the school nurse to ensure we have physician orders, medications at school, and health care plan in place **prior** to starting school. Per state law RCW 28A.210.320 and district policy your **student may be excluded from school without this info and medication on file. PLEASE REFER TO EXCLUSION LETTER TO CONTACT HEALTH SERVICES.**

- My student has NONE of the health conditions listed above**
- Other health care needs:** _____

MEDICATION

Does your student take any medication? No Yes
Will medication be needed at school? No Yes
Name of medication: _____ Reason for medication: _____ Home School
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*** Please note students requiring medication during the school day (herbal, over the counter or prescription) MUST have a written physician order and parent signature on file at school. PLEASE SEE MEDICATION AUTH FOR FURTHER INSTRUCTIONS.**

CONTACT INFORMATION

Providing your contact information here will not update contact information at the district office. If you need to update your contact information, please contact the registrars at 360.833.5410.

1. Parent/Guardian: _____ Phone _____ Additional Phone _____
2. Parent/Guardian: _____ Phone _____ Additional Phone _____
3. Health Care Provider: _____ Phone _____

I understand that the information above may be shared in a confidential manner with appropriate school staff on a need to know basis to keep my child safe during the school day. I authorize school staff to request emergency medical services for my child if needed.

Parent Signature _____ Date _____