Washougal School District
Student Health History & Emergency Medical Treatment Consent Form

For office use only.
Reviewed by:

Information on this form is required to be filled out (updated) each school year. **School Year:_____**

Student Name:_____ Birthdate:_____ Gender:_____
Legal Name: First Middle Last
School: _____ Gr:_____ Teacher_____

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 condition** requiring **immediate** assistance and/or medication at school? ☐YES ☐NO
If yes, 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.**

☐ **My student has NONE of the health conditions listed above**

☐ Other health care needs:_____

☐ Wears glasses/contacts. Please specify: ☐ Glasses ☐ Contacts

☐ Hearing loss. Please specify: ☐ Right Ear ☐ Left Ear ☐Hearing Aids

MEDICATION

Does your student take any medication? ☐ YES ☐ NO
Will medication be needed at school? ☐ YES ☐ NO

Meds taken at:
Name of medication:_____Reason for medication_____ ☐ Home ☐ School
Name of medication:_____Reason for medication_____ ☐ Home ☐ School
Name of medication:_____Reason for medication_____ ☐ Home ☐ School

*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 AUTHORIZATION FOR FURTHER INSTRUCTIONS.

CONTACT INFORMATION

Parent/Guardian/Emergency Contacts	**Relationship**	**Phone numbers**
Call 1st:		Cell: Home:
		Work:
Call 2nd:		Cell: Home:
		Work:
Call 3rd:		Cell: Home:
		Work:

Student's doctor/healthcare provider:_____Phone:_____

Insurance Provider:_____

The information on this form may be shared confidentially with school staff and emergency responders as needed. In the event of a medical emergency with my child, I understand every effort will be made to inform me. If emergency care is needed, I authorize qualified professionals to provide assessment, diagnosis and any necessary emergency treatment. I understand that the school district assumes no financial liability for expenses incurred due to the accident, injury and/or unforeseen circumstance.

_____ _____ _____
Parent/Guardian signature Printed name Date

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