

# Confidential Emergency Health Information

For use by IHS, SHS, LHS, TMCH, and PCFC

**THIS FORM MUST BE COMPLETED & RETURNED IMMEDIATELY!!**

Name: \_\_\_\_\_ B/D \_\_\_\_\_  
Last First MI

School Year: \_\_\_\_\_ School: \_\_\_\_\_

**ALERT TO PARENTS:** If your child has a life-threatening health condition (severe bee sting allergy, severe food allergy, severe asthma, Epi-Pen, unstable Diabetes, severe seizures etc.), Washington State Law SHB 2834 requires that a medication or treatment order and a Nursing Plan be in place before your child's first day of school each year. Immediately contact your child's School Nurse.

In order to provide a safe and healthy environment for your child this information will be accessible to the following people: Principal, nurse, your child's teachers, secretaries, personnel responsible for health room coverage, and medical emergency personnel.

**A. Medical History** (check the ones that apply to your child and describe under the comment section)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> ADHD                 | <input type="checkbox"/> Color Blindness    | <input type="checkbox"/> Seizures              |
| <input type="checkbox"/> ADD                  | <input type="checkbox"/> Depression         | <input type="checkbox"/> Vision Problems       |
| <input type="checkbox"/> Anxiety/Panic Attack | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Other:                |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Epi-Pen            | <input type="checkbox"/> Explain: _____        |
| <input type="checkbox"/> Autism               | <input type="checkbox"/> Hearing Problems   |  |
| <input type="checkbox"/> Bee Sting Allergy    | <input type="checkbox"/> Heart Condition    | <input type="checkbox"/> PE Activity:          |
| <input type="checkbox"/> Bleeding Disorder    | <input type="checkbox"/> Hyperventilation   | <input type="checkbox"/> <b>Limited</b>        |
| <input type="checkbox"/> Bowel Problem        | <input type="checkbox"/> Migraine Headache  | <input type="checkbox"/> <b>Not Limited</b>    |
| <input type="checkbox"/> Cerebral Palsy       | <input type="checkbox"/> Orthopedic Problem | <input type="checkbox"/> <b>Explain:</b> _____ |

Comments: \_\_\_\_\_

**B. ALLERGIES** List all allergies your child has including allergies to medications/bee stings/food.

Cause of the allergy _____	Treatment _____
Cause of the allergy _____	Treatment _____
Cause of the allergy _____	Treatment _____

**C. MEDICATION:** Is medication given at home? Yes  No

Name of medication	1) _____	Used to treat: 1) _____
	2) _____	Used to treat: 2) _____

Is medication needed at school? Yes  No

Name of medication	1) _____	Used to treat: 1) _____
	2) _____	Used to treat: 2) _____

**\*\*Is your student taking any herbal medicine?** Yes  No

Name of medication.	1) _____	Used to treat: 1) _____
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Before medication can be administered at school, a medication administration form, available in the office, must be completed by the parent and licensed health care provider and kept on file.

**OVER>**

D. List any operations, injuries, or hospitalizations. Give dates: \_\_\_\_\_  
\_\_\_\_\_

E. Does your son/daughter wear glasses? Yes  No  Contact Lenses? Yes  No

F. Name of Physician/Health Care Provider: \_\_\_\_\_ Phone # \_\_\_\_\_  
Name of Dentist: \_\_\_\_\_ Phone # \_\_\_\_\_  
Hospital Preference: \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_

G. Parents Name: \_\_\_\_\_  
Mother Father  
Home Phone: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Work Phone: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Pager Number: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Cell Number: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Student lives with: Both parents:  Mother:  Father:   
Other:  Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone# \_\_\_\_\_

H. IN THE EVENT OF A MEDICAL EMERGENCY, IF A PARENT OR GUARDIAN CANNOT BE REACHED,  
PLEASE CONTACT: (Provide a local contact)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone Number: ( ) \_\_\_\_\_ Cell Number: ( ) \_\_\_\_\_

**If the parents and authorized licensed health care provider cannot be reached at the time of an emergency and if an immediate observation or treatment is urgent in the judgment of the school authorities, I authorize and direct the school authorities to send the child (properly accompanied) to the hospital or licensed health care provider most accessible.**

**PARENTS/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_