Stevenson-Carson School District
Student Health History & Emergency Medical Treatment Consent Form

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

Student Name	**School**	**Grade**
Teacher	**Birth Date**	**Gender**

HEALTH INFORMATION	**Yes**	**No**	**Explanation if "Yes"**
Allergies/Anaphylaxis	☐	☐	Triggers/Allergens: _____ Epi-Pen required at school ☐ YES ☐ NO
Asthma	☐	☐	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
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	☐	☐	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**	
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 accident, injury and/or unforeseen circumstance.

_____ _____ _____
Parent/Guardian Signature Printed Name Date

Rev. 5/2019 *Reviewed by School Nurse_____*