Bellingham Public Schools
...where *every* student learns

ANNUAL STUDENT HEALTH CONCERNS DOCUMENT

Information on this form is to be filled out for each new school year and is designed to aid school staff in anticipating any health concerns that might affect your student's safety or learning. Checked health conditions will be shared with school personnel on a "need to know" basis.

Student Name: _____ School Year: _____

School: _____ Grade: _____ Birthdate: _____

If student needs medication during the school day, an Authorization for Medications at School Form is required.

LIFE THREATENING CONDITIONS

The nurse must know of any LIFE-THREATENING conditions (severe allergy with anaphylaxis, asthma, diabetes or seizure disorders) prior to attending school, as these require a health care plan in place (per RCW 28A.210.320).

- ☐ **Life threatening condition requiring epinephrine auto injector**:
  Life threatening Allergen(s) _____
- ☐ **Asthma** / Medication used to control asthma symptoms_____
- ☐ **Diabetes Type _____** Using ❑ insulin pump, ❑ insulin pen, ❑ insulin vial/syringe, ❑ oral medications
- ☐ **Seizure Disorder** / Meds used to control seizures: _____ Last seizure on: _____
- ☐ **Other life threatening condition(s):**_____
  _____

SPECIAL HEALTH CARE PLANNING

check appropriate boxes and contact your school nurse for a health care plan. Treatment order from the doctor is required for most special health care needs other than mobility aids.

❑ Tube Feeding ❑ Tracheostomy ❑ Catheter ❑ Intravenous line or PICC line ❑ Oxygen
❑ Other medical treatment:_____
❑ My child requires a mobility aid, such as a wheel chair, walker, brace:_____

For all other health conditions that need accommodations during the school day such as allergies, medications, or treatments, contact the school nurse directly.

AUTHORIZATION FOR EMERGENCY PROCEDURE & IMMUNIZATION INFORMATION RECORDING

If the parent/guardian and Licensed Health Care Provider named on the registration record cannot be reached at the time of an emergency and if immediate observation or treatment is urgent in the judgment of the school authorities, I authorize and direct the school authorities to send my child (properly accompanied) to the hospital or Licensed Health Care Provider most easily accessible. I understand that I will assume full responsibility for the payment of any service rendered. I give permission to my child's school to add immunization information with the Immunization Information System to help the school maintain my child's school record.

Parent/Guardian Signature: _____ Date: _____ Phone Number: _____