Methow Valley School District

Methow Valley Elementary School 509.996.2186 / fax 509.996.9202
Liberty Bell High School 509.996.2215 / fax 509.996.3609

2013-14

STUDENT HEALTH INFORMATION

The information below is to help school staff understand any health concerns that might affect your child's safety or learning.

Student's Name: _____ _____ _____
First *Middle* *Last*

Date of Birth: _____ **Sex:** _____ **Grade:** _____

Parent/Guardian name(s): _____

Daytime phone: #1_____ **#2**_____ **#3**_____

MEDICAL HISTORY *Please mark if your child has any of the following health conditions*:

Does your child have a life-threatening health condition? ❒ No ❒ Yes— ***If yes, a meeting with the school nurse is required*** *so that medication or treatment orders and a health care plan may be in place prior to starting school.*

____ Asthma ❒ Will need inhaler at school ❒ Seen in hospital/Emergency Room in last five years for asthma
____ Severe allergy requiring Epi-pen? Allergy to: ❒ Food ❒ Bees/insects ❒ Plants ❒ Animals ❒ Drugs
____ Diabetes ❒ requires insulin injection
____ Seizure disorder
____ Heart condition
____ Frequent or severe headache
____ Behavior or emotional concerns
____ ADD/ADHD
____ Other health concerns you want us to know about:

Does your child wear **hearing aids**? ❒Yes ❒No
Does your child wear **glasses**/**contacts**? ❒Yes ❒No

Do any of the above condition(s) limit/affect your child at school? ❒ No ❒ Yes, explain:

❒ **My child has NO HEALTH PROBLEMS**

MEDICATION

Does your child take any medication? ❒ No ❒ Yes, name of medication:

Reason for taking medication:

Will medication be needed at school? ❒ No ❒ Yes*

*** If your child needs medication at school, please contact your health care provider or the school for the "Medication Authorization" form which must be completed <u>every year</u> before any medication may be administered at school.**

MEDICAL

Does your child have a health care provider? ❒ Yes ❒ No
Name of child's health care provider _____phone number _____

DENTAL

Does your child have a dentist? ❒ Yes ❒ No
Name of child's dentist _____ phone number _____

INSURANCE

Does your child have medical insurance coverage? ❒ Yes ❒ No ❒ Don't know
Does your child have dental insurance coverage? ❒ Yes ❒ No ❒ Don't know
Would you like assistance finding insurance for your child? ❒ Yes ❒ No

AUTHORIZATION FOR SHARING HEALTH INFORMATION I understand that the information given above may be shared with some school staff to provide for the health and safety of my child.

Parent/Guardian Signature _____ Date _____