Omak School District

P.O. Box 833, Omak WA 98841 509.826.8395 / fax 509.826.8515

2020-21

STUDENT HEALTH INFORMATION

MUST BE COMPLETED ANNUALLY

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**_____

❒ **My child has NO HEALTH PROBLEMS**

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

____ Asthma ❒ Will need inhaler at school ❒ Seen in hospital/Emergency Room in last five years for asthma
____ Severe allergy requiring Epi-pen? ❒ Food_____ ❒ Bees/insects ❒ Plants ❒ Animals ❒ Drugs _____
____ Non-severe allergy to: ❒ Food_____ ❒ Bees/insects ❒ Plants ❒ Animals ❒ Drugs_____
____ Diabetes ❒ requires insulin injection ❒ insulin pump
____ Seizure disorder
____ Heart condition
____ Frequent or severe headache
____ Behavior or emotional concerns
____ ADD/ADHD
____ Other - please explain any health concerns you think we should know about at school:
Do any of the above condition(s) limit/affect your child at school? ❒ No ❒ Yes explain:
Does your child wear hearing aids? ❒No ❒Yes Glasses/contacts? ❒No ❒Yes Last eye exam _____

LIFE-THREATENING CONDITIONS

Does your child have a life-threatening health condition? ❒ No ❒ Yes ***** Describe:

*** If yes, a meeting with the school nurse is required. Washington State Law requires that medication or treatment orders and a health care plan be in place prior to starting school.**

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 the school for the "Medication Authorization" form. This form must be completed every year before any medication may be administered at school.**

Medical/Dental/Insurance

Name of student's Health Care Provider _____ Ph: _____
Name of student's Dentist _____Ph:_____
Name of Insurance Company _____ Policy No. _____

Consent for Medical Release, Sharing Health Information, and Adding to Immunization System

- In the event of an accident or illness, I understand that reasonable effort will be made to contact the parent immediately. However, if I am not available, I authorize the school district to secure emergency medical care as needed.
- I understand that the school district does not purchase or have medical/dental/hospitalization insurance to cover injuries to or losses of life of students, or to indemnify parents for expenses in connection therewith, and that such insurance, if desired, must be purchased by the parent or guardian.
- I understand that the information given above may be shared with some school staff to provide for the health and safety of my child.
- I give permission to my child's school to add immunization information into the Immunization Information System to help the school maintain my child's record

Parent/Guardian Signature _____ Date _____