

Olympia School District  
**STUDENT HEALTH INFORMATION**

Student's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Last First Middle

Gender: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_  
Street City

Parent/Legal Guardian	Home/Msg Phone	Cellular Phone	Work Phone
Mother/Legal Guardian's Name: _____	_____	_____	_____
Father/Legal Guardian's Name: _____	_____	_____	_____

**Student lives with:**

- Both Mother/Father                       Legal Guardian  
 Mother only                                       Other Legal Guardian: \_\_\_\_\_  
 Father only

**Health Care Provider:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Medical Insurance:**

- Medical Coupons     Private     Military     None     Other: \_\_\_\_\_

LIFE-THREATENING CONDITIONS	OTHER HEALTH CONDITIONS														
<p><b>Washington State law requires medication or treatment orders and a health care plan be in place. Please contact the school nurse.</b></p> <p>Does your child have a life-threatening Allergy?  <input type="checkbox"/> Yes                      <input type="checkbox"/> No</p> <p>Allergic to: _____            _____</p> <p>Describe Reaction: _____            _____</p> <p>Date of Last Reaction: _____</p> <p><input type="checkbox"/> Seizures: Type _____            _____</p> <p><input type="checkbox"/> Cardiac: Describe _____            _____</p> <p><input type="checkbox"/> Diabetes: Type _____            _____</p> <p>Does your child have severe Asthma?  <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Hospitalized / Emergency Treatment within past year.  <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Allergies - please list: _____            _____</p> <p>Mild Reactions: _____            _____</p> <p><input type="checkbox"/> Asthma:  <input type="checkbox"/> with inhaler    <input type="checkbox"/> without inhaler            Describe: _____            _____</p> <p><input type="checkbox"/> Other Health Conditions: _____            _____</p> <p style="text-align: center;"><b>MEDICATIONS</b></p> <p><b>If your child needs to take any medication at school, please contact the office for the necessary authorization form. This form must be completed prior to any medication being brought to school.</b></p> <p><b>Medication(s):</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 70%;">Currently Used</td> <td style="width: 30%;">Taken At:</td> </tr> <tr> <td>1. _____</td> <td><input type="checkbox"/> School</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Home</td> </tr> <tr> <td>2. _____</td> <td><input type="checkbox"/> School</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Home</td> </tr> <tr> <td>3. _____</td> <td><input type="checkbox"/> School</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Home</td> </tr> </table>	Currently Used	Taken At:	1. _____	<input type="checkbox"/> School		<input type="checkbox"/> Home	2. _____	<input type="checkbox"/> School		<input type="checkbox"/> Home	3. _____	<input type="checkbox"/> School		<input type="checkbox"/> Home
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If your child is ill/injured at school, we will contact the parent/legal guardian or emergency contact person if at all possible and call 911, if the injury or illness warrants it.

I consent to the release of medical information related to my child, to school personnel, as needed, to ensure his/her safety at school. I understand that it will be my responsibility to arrange for payment for medical care, should my child be ill/injured. I have read and understand this form.

**Parent/Legal Guardian Sign Here:** \_\_\_\_\_ **Date:** \_\_\_\_\_