GLENWOOD SCHOOL DISTRICT

STUDENT HEALTH REGISTRATION FORM & CONSENT FOR EMERGENCY MEDICAL TREATMENT

Student Name: _____ Date of Birth: _____ Grade: _____ Gender: _____

Home address: _____

Mailing address (if different): _____

Living with (circle one): Both parents Mother only Father only Self Legal guardian Other: _____

Parent/Guardian: _____ Best phone: _____ Email: _____

Parent/Guardian: _____ Best phone: _____ Email: _____

Emergency Contact: _____ Phone number: _____

Doctor: _____ Phone: _____ Dentist: _____ Phone: _____

PLEASE CIRCLE ANY LIFE-THREATENING CONDITIONS

State Law, RCW 28A.210 requires that students with life-threatening health conditions must have physician orders and a nursing care plan before attending school. This information may be shared with school district staff that have a "need to know," in order to provide a healthy, safe environment.

NO KNOWN HEALTH CONCERNS ☐	
RESPIRATORY PROBLEMS: Asthma, cystic fibrosis, etc.	Severity: Special needs/medications:
SEVERE ALLERGY TO: Food, insects, medication Life-threatening: ☐ Yes ☐ No	Allergen/ reaction: Medications needed:
SEIZURE DISORDER: Epilepsy etc.	Type: Special needs/medications:
A.D.D./ A.D.H.D (circle one)	Special needs/medications:
DIABETES	Type: Special needs/medications:
NEUROLOGICAL CONDITION: Hydrocephalus, cerebral palsy, etc.	Type & Reaction: Medication needed:
HEART CONDITIONS	Type: Special needs:
ORTHOPEDIC PROBLEMS: arthritis, scoliosis, braces, wheelchair	Type: Surgeries/limitations:
CANCER, LEUKEMIA, TUMORS	Type: Special needs/medications:
DIGESTIVE PROLEMS: ulcers, colitis, etc.	Type: Special needs/medications:
URINARY/KIDNEY DISORDER	Type: Special needs/medications:
VISION PROBLEMS OR COMPLETE LOSS OF	Type: Special needs/contacts/glasses
HEARING PROBLEMS OR COMPLETE LOSS OF	Type: Special needs:
SERIOUS ILLNESS, INJURIES, OPERATIONS	Type: Special needs:
OTHER DIAGNOSED HEALTH PROBLEMS	Type: Special needs

IF MEDICATIONS ARE NEEDED AT SCHOOL PLEASE CONTACT THE SCHOOL OFFICE FOR APPROPRIATE FORMS

I will keep the school health services informed throughout the year regarding any changes in health status and/or contact information. I understand that if either parent/guardian or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize the school staff to request emergency medical services (911). I understand I may be responsible for the payment of any medical services if needed.

Parent/guardian signature: _____ Date: _____