Clover Park
School District
Health Services

Reviewed by:____________Date:_________

Reviewed by:____________Date:_________

Life Threatening Condition Information

Student Name ______________ Signature of Parent/Guardian ______________ Date ______

DOES YOUR CHILD HAVE A CONDITION THAT COULD BE LIFE THREATENING? ☐ **YES** ☐ **NO**

Your child's life threatening health condition is ☐ Asthma ☐ Allergy ☐ Seizures ☐ Other:__________________________

Age at diagnosis _____. Health care specialist managing condition is_________________________ Phone_______________

Did you have to take your child to (check one): ☐ Provider's office? ☐ Emergency Room? ☐ Hospital overnight?

Will your child be able to indicate to school staff when they are having a problem? ☐ Yes ☐ No

Accommodations that your child will need at school:____

Suggestions on managing your child's condition:

When this happens… Do this…

Asthma

Things that may trigger an asthma episode *(check all that apply)*:

☐ Exercise ☐ Respiratory infections ☐ Strong odors or fumes ☐ Emotions/fatigue ☐ Pollens/molds

☐ Weather/temperature change ☐ Animals ☐ Other:____

When was the last time your child used his/her inhaler or nebulizer?______________________________

Has your child needed oral steroids for treatment of his/her asthma in the last two years? ☐ Yes ☐ No

Has your child needed emergency medical care for asthma symptoms in the last year? ☐Yes ☐ No Hospitalized ☐Yes ☐No

I would rate my child's asthma condition on a scale of 1 to 10 this way – *circle-*

(not severe) 0 1 2 3 4 5 6 7 8 9 10 (severe)

Food & Insect Allergy

Food/insect that causes allergic reaction:____

Most recent allergic reaction was on (approximate date):_______________________________________

Describe the allergic reaction when it first occurred/made you aware, symptoms seen:__________________

Check all that apply:

☐ Hives ☐ Nausea, stomach cramps, vomiting or diarrhea ☐ Itching and swelling of the lips, tongue, or mouth

☐ Shortness of breath, hoarseness ☐ Symptoms required **Epipen** use

☐ Required emergency medical care for allergy reaction in the last year ☐ Allergy has required emergency medical care

☐ Other:____

Seizures

Usual type of seizures: ______________________________________ Date of last seizure?____________

Number of times seizures occur in a day_________________________ in a month______________________

Check all that apply:

☐ Vagus Nerve Stimulator ☐ Absence (staring spells) ☐ Seizures last longer than 5 minutes

☐ Seizure occurred with fever as an infant or toddler ☐ Clusters of seizures one right after another

☐ Breathing severely interrupted or stopped (needed CPR) ☐ Required emergency medical care for seizures in last year

Clover Park School District Health Services

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Health Information

Student Name ______________________ **Birth Date** __________ Sex ☐ F ☐ M Grade ______

Health Care Provider ______________________ Dentist ______________________

Last medical examination (date)__________ By Dr. ______________ Phone __________

Last dental examination (date) __________ By Dr. ______________ Phone __________

Type of Medical Insurance (check one) ☐ Private ☐ Medical Coupons ☐ Military ☐ None ☐ Other: __________

❖**Alert to Parents/Guardians: If your child has a serious medical condition, *it is vital that you discuss this with your health para/LPN, School RN, and teacher(s) immediately*. WA state law requires that if your child has a medical condition that may be life threatening (for example asthma, diabetes, severe allergy with anaphylaxis), <u>any necessary medication, supplies, care plan and physician's orders must be in place prior to them starting school</u>. This information, with confidentiality in mind, will be shared with district staff as needed.**

Please remember to update the school with any changes in your child's health condition.

A. Students Medical History (check any that have been diagnosed by your health care provider)

☐ **Asthma**
☐ **Diabetes** ☐ Type 1 ☐ Type 2
☐ **Seizure Disorder** ☐ VNS
☐ **Heart Condition**
☐ **Transplant**
☐ **Cancer**
☐ **Autoimmune Condition**
☐ Kidney/Urinary/Bowel Condition
☐ Orthopedic Condition__________
☐ Migraines
☐ Eczema
☐ Vision Problem
☐ Hearing Problem
☐ Frequent ear infections/tubes
☐ Menstrual Problems
☐ Alcohol/Drug Misuse
☐ Anorexia/Bulimia
☐ Dental ☐ Speech problem
☐ ADD ☐ ADHD ☐ ASD
☐ Mental Health__________
☐ Physical Disability ☐ CP

If you have checked any of the above, or your child has a medical condition not listed, please explain and give dates:

____

____

B. Allergy: ☐ Nuts ☐ Food ☐ Bee ☐ Insect ☐ Animals ☐ Pollen ☐ Drugs ☐ Other: __________

Have you ever needed to seek medical attention for this allergy? ☐ Yes ☐ No

Has your child ever had allergy testing? ☐ Yes ☐ No The allergic reaction is ☐ Mild ☐ Moderate ☐ **Severe**

Is/was an **Epipen prescribed?** ☐ Yes ☐ No

Identify the item and explain: ______________________________

C. Medications: (Include prescription, over-the-counter and herbal medication.)

Medication Name	Used to Treat What Condition?	Taken at Home	Taken at School
______________	______________	☐ Yes ☐ No	☐ Yes ☐ No
______________	______________	☐ Yes ☐ No	☐ Yes ☐ No
______________	______________	☐ Yes ☐ No	☐ Yes ☐ No

Before medication of any kind (over the counter and prescribed) can be administered at school, medication orders for school must be completed by parent/guardian and health care provider. All medication must be in the original container labeled by the pharmacy. The medication ordered must be the same as the pharmacy label.

D. List any hospitalizations or prolonged illness/injury and give dates: ______________________

____

E. Recommended Physical Activity: ☐ Full Activity ☐ Modified/Restricted Activity

If modified/restricted, please explain: ______________________________

F. Check all that apply: ☐ Glasses ☐ Contact Lenses ☐ Hearing Aids

Does your child have a health condition that requires medical equipment at school (for example, glucose monitor, feeding tube, oxygen, pump, wheelchair, and/or walker)? ☐ Yes ☐ No Please specify: __________

____

G. Are there any other social or health agencies which might have additional information about your child?

____

__________ Date ______________________ Signature of Parent/Guardian __________ Telephone

Please fill out the back of this form.