REGISTRATION FORM 1F-15 PART B: HEALTH RECORD Spokane Public Schools•Spokane, Washington

Student_____ Sex: ☐ M ☐ F Birth Date_____
Last First Middle Month Day Year

Parent/Guardian_____ Home Phone_____
Last First Initial

Address_____ Work Phone_____
Number N-S-E-W Street

School_____ Grade_____ Room_____

Dear Parent:

Please describe your child's current health condition on the form below. It is important that you keep the school informed of any changes in health or medication which would affect your child at school. If your child needs to take medication at school, please notify the school office.

☐ **CHECK HERE IF ANY OF THE HEALTH CONDITIONS ARE LIFE THREATENING AND WOULD REQUIRE EMERGENCY MEDICATION OR TREATMENT AT SCHOOL.** **Please circle the condition(s) that are life threatening.**

RCW 28A.210 requires that physician orders and a nursing care plan must be in place before a student attends school.

☐ The health condition(s) I have described below is/are of sufficient concern that I will contact the school nurse at the enrolling school.

CURRENT HEALTH CONDITIONS

ASTHMA	Medications needed **AT** school: ☐ **Yes (Physician's orders & nursing care plan required, available in office)**
BEHAVIORAL/MENTAL HEALTH, ADD/ADHD, Autism, Depression, etc.	Type: Medications needed **AT** school: ☐ Yes (Medication orders required, available in school office)
BLOOD DISORDER Anemia, Hemophilia, Sickle Cell, etc.	Type: Accommodations/ Needs:
CARDIAC Heart Murmur, Hypertension, etc.	Type: Limitations: ☐ **Yes (Physician's note required)**
*DIABETES	Type 1 **(Physician's orders & nursing plan required: Purple Diabetes Packet in school office)** Type 2 Medications:
DIGESTIVE DISORDER Food/Milk Intolerance, Celiac, Colitis	Type: Food Substitutions Needed: ☐ **Yes (Diet prescription form required; available in school office)**
EATING/SWALLOWING CONCERNS (Notify Speech Language Pathologist)	Describe: Accommodation/Needs:
*FOOD ALLERGY **Life Threatening (Anaphylaxis)**	Foods: **(Physician's orders, nursing care plan & medication required: Blue Allergy Packet in school office)**
HEARING LOSS (Notify Audiologist)	☐ **Wears Hearing Aids** Accommodations/Needs:
*IMMUNOSUPRESSION/MALINANCY Cancer, Transplant, etc.	Type: Accommodation/Needs:
MEDICATION/DRUG ALLERGY	Type:
NEUROLOGICAL PROBLEM Hydrocephalus, Cerebral Palsy, etc.	Type: Accommodation/Needs:
NON-FOOD ALLERGY Insects, Latex, etc.	Type: *Life threatening reaction: ☐ **Yes (Medication orders required, available in school office)**
ORTHOPEDIC PROBLEM Arthritis, Muscular Dystrophy, etc.	Type: Limitations: ☐ **Yes (Physician's note required)**
RESPIRATORY PROBLEM Cystic Fibrosis, Tuberculosis, etc.	Type: Medications **AT** needed school: ☐**Yes (Medication orders required, available in school office)**
*SEIZURE DISORDER Epilepsy, etc.	Type: Accommodations/Needs:
SKIN DISORDER Eczema, Psoriasis, etc.	Describe: Accommodations/Needs:
TRAUMATIC BRAIN INJURY Concussions, Closed Head Injury, etc.	Describe: Accommodations/Needs:
URINARY/KIDNEY DISORDER Nephritis, etc.	Type: Accommodations/Needs:
VISION LOSS	☐ **Glasses** ☐**Contacts** Accommodations/Needs:
OTHER HEALTH PROBLEMS	Describe: Accommodations/Needs:

☐ **No health problems to my knowledge**

***Notification of school nurse required**

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Parent/Guardian Signature **Date**