

Ellensburg School District #401

ANNUAL STUDENT HEALTH INVENTORY FORM

This questionnaire is designed to aid school staff in anticipating any health concerns that might impact your student's safety or learning.

Student Name: _____ **School Year:** _____

School: _____ **Grade** _____ **Gender** _____ **Date of Birth:** _____

<p>LIFE THREATENING ALLERGY: <u>Requiring an Epinephrine Auto Injector in school and medical follow-up. ** Must contact school nurse.</u></p> <p><input type="checkbox"/> Life Threatening allergy to: _____ _____ _____</p> <p><input type="checkbox"/> Other allergies, not life-threatening, but needs to avoid: _____</p> <p>ASTHMA:</p> <p><input type="checkbox"/> Intermittent: Student who has symptoms of wheezing and coughing no more than 2 days a week, with nighttime flare-ups twice a month or less. Outside of these few episodes, free of symptoms.</p> <p><input type="checkbox"/> Mild: Symptoms occur more than twice a week but less than once a day, flare-ups may effect activity.</p> <p><input type="checkbox"/> Moderate: Symptoms occur daily, flare-ups usually last several days. Symptoms disrupt normal activities and make it difficult to sleep.</p> <p><input type="checkbox"/> Severe: Symptoms occur daily and often, also curtail the student's activities and disrupt sleep.</p> <p><input type="checkbox"/> Inhaler/medications at school <i>* See instructions below</i></p> <p>ATTENTION DEFICIT DISORDER:</p> <p><input type="checkbox"/> Medication at school <i>*See instructions below</i></p> <p><input type="checkbox"/> Medication at Home</p> <p><input type="checkbox"/> Diagnosed, un-medicated</p> <p>DIABETES: ** Must contact the school nurse</p> <p><input type="checkbox"/> Insulin dependent and will need a school program set up</p> <p><input type="checkbox"/> Not insulin dependent and will need a school program set up</p>	<p>HEARING CONCERNS:</p> <p><input type="checkbox"/> History of hearing loss: Right Ear____ Left Ear____</p> <p><input type="checkbox"/> Wears hearing aid in left and/or right ear (circle applicable)</p> <p>VISION PROBLEMS:</p> <p><input type="checkbox"/> Blind in one eye: Right Eye____ Left Eye____</p> <p><input type="checkbox"/> Other vision issue: _____</p> <p><input type="checkbox"/> Wears Glasses</p> <p><input type="checkbox"/> Wears Contacts</p> <p>SEIZURES: ** Must contact school nurse</p> <p><input type="checkbox"/> Medication at school <i>* See instructions below</i></p> <p><input type="checkbox"/> Medication at home</p> <p><input type="checkbox"/> History of seizures, but not presently medicated Date of last seizure: _____</p> <p>PHYSICAL RESTRICTIONS THAT WOULD LIMIT ACTIVITY:</p> <p><input type="checkbox"/> Skeletal (bone) or muscular limitations: _____</p> <p>OTHER HEALTH OR MEDICATION NEEDS:</p> <p><input type="checkbox"/> Medication your child needs at school not listed: <i>*See instructions below</i> _____ _____</p> <p>ADDITIONAL HEALTH CONCERNS THAT WOULD AFFECT SCHOOL PERFORMANCE: _____ _____ _____</p>
--	---

* **MEDICATION AT SCHOOL: Must submit Authorization of Medication at School Form, which can be obtained from the school office. This form must be completed by a Licensed Health Care Provider before medication can be administered.**

** **LIFE-THREATENING CONDITION: Must contact school nurse! A healthcare plan and all medications must be in place with the school before the student can attend school.**

AUTHORIZATION FOR EMERGENCY PROCEDURE:

If the parents/guardians and Licensed Health Care Provider named on the registration record cannot be reached at the time of an emergency and if immediate observation or treatment is urgent in the judgment of the school authorities, I authorize and direct the school authorities to send my child (properly accompanied) to the hospital or Licensed Health Care Provider most easily accessible. I understand that I will assume full responsibility for the payment of any service rendered.

The above checked health concerns may be shared with school personnel on a "need to know" basis.

 Signature of Parent/Guardian

 Date Signed

The Ellensburg School District does not discriminate in any programs or activities on the basis of sex, race, creed, religion, color, national origin, age, veteran or military status, sexual orientation, gender expression or identity, disability, or the use of a trained dog guide or service animal and provides equal access to the Boy Scouts and other designated youth groups. The following employees have been designated to handle questions and complaints of alleged discrimination: Cole Kanyer, Title IX Coordinator, 509-925-8315, cole.kanyer@esd401.org, 1203 E. Capitol Avenue, Ellensburg, WA 98926, Kim Snider, Civil Rights Coordinator, 509-925-8007, kim.snider@esd401.org, and Section 504 Coordinator, Patty Kimmel, 509-925-8115, patricia.kimmel@esd401.org, 1300 East Third Avenue, Ellensburg, WA 98926.