



Arlington School District

315 N French Ave, Arlington, WA 98223

<http://www.asd.wednet.edu>

Health Concerns

For Office Use Only:

Completed Medication Orders ☐

Medical Supplies Received ☐

Medications Received ☐

This information is needed to plan an appropriate program for your student and to prepare for any emergency situation, if one should arise. Your building nurse will contact you if there are any additional questions. This form is to be completed by the parent/guardian. The law requires that life threatening conditions such as anaphylaxis, asthma, diabetes, or seizures have a completed care plan, completed medication orders, medical supplies and medication(s) supplied to the school prior to the student's first day of school. Please contact the building nurse as soon as possible to ensure the paperwork is complete.

Does your child have any current health conditions?

Yes

No

If yes, fill in all appropriate information. If no, skip to signature on page 2.

Medical History (Indicate all that apply)

Life Threatening Health Condition (please contact nurse for care plan)

*Hemophilia

☐

*Diabetes Type I

*Anaphylactic Condition (EpiPen)

☐

*EpiPen prescribed

*Asthma

☐

*Seizure Condition

*Cardiac Condition

Cardio Vascular

Diagnosed Condition: _____

Please explain: _____

Hematology (Blood)

Sickle Cell Anemia

Other blood condition, explain: _____

Endocrine, Allergy, Immune System

Food Allergy

List Allergy: _____

Insect Allergy

List Allergy: _____

Cystic Fibrosis

Thyroid Disease

Diabetes Type II

Other: _____

Gastrointestinal-Intestinal, Dental & Oral Conditions

Celiac Disease

Crohn's/Colitis

Lactose Intolerance

Gastroesophageal Reflux

Irritable Bowel

Liver Disease

Oral Condition

Dental Condition

Other: _____

Skin & Subcutaneous Tissue

Contact Dermatitis

Eczema

Other: _____

Nervous System

☐ Autism

☐ Traumatic Brain Injury

☐ Cerebral Palsy

☐ Developmental Disability

☐ Migraines

☐ Headaches

☐ Sensory Condition

☐ Paralysis

☐ Speech Impairment

☐ Shunt

☐ Spinal Cord Injury

☐ Spina Bifida

☐ ADHD/ADD diagnosed

☐ Recent Concussion

Date of concussion: _____

Concussion diagnosed by: _____

Other: _____

Mental or Behavioral Health Condition

☐ Sleep Disorder

☐ Anxiety

Other: _____

☐ Depression

Respiratory

☐ Reactive Airway Disease

Other: _____

Musculoskeletal & Connective Tissue

☐ Juvenile Rheumatoid Arthritis

☐ Muscular Dystrophy

Other: _____

Renal & Genitourinary

☐ Chronic Urinary Tract

☐ Dysmenorrhea (painful periods)

Infection Incontinence

☐ Other: _____

Neoplasm (Cancer/Tumors)

Please explain: _____

Eye & Ear

Visually Impaired

☐ Wears Glasses/Contacts

Hearing Impaired

Wears Hearing Aids

Chronic Ear Infections

Other: _____

MEDICATIONS: (Please report all medications that your student takes both at home and at school)

Is medication needed at home? Is medication needed at school? Yes No

Please list: _____

Medication at school? Yes No

Please list: _____

State law requires written permission from parent/guardian and a licensed health care provider before any medications, prescription, or over-the-counter medication, may be taken at school. Forms are available from the school health rooms, school office, or from the Arlington Public Schools website at: www.asd.wednet.edu/for_parents/district_forms.

If parent/guardian or authorized emergency contact cannot be reached at the time of a medical emergency, and if immediate care is urgent in the judgment of the school authorities, I authorize and direct the school authorities to send the student to the hospital or doctor most accessible. I understand that I will assume full responsibility for the payment of any services rendered. I understand that the information given above will be shared with appropriate school staff that needs to know in order to provide for the health and safety of my student.

I give permission to my child's school to add immunization information into the Immunization Information System to help the school maintain my child's record

Parent/Guardian Name	Parent/Guardian Signature	Date
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Parent/Guardian Name	Parent/Guardian Signature	Date
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