NESPELEM SCHOOL DISTRICT

Student Health Information 2025-2026

Student Name: _____ Date of Birth _____

Grade _____ Age _____ Male/Female _____

Life Threatening Medical Conditions (Check all that apply):
If your child has a life threatening medical condition, state law requires a medication/treatment order from a Health Care Provider, and a school nurse Health Care Plan before your child can attend school. Does your child have any of the following conditions? Please explain:

Y/N Severe allergic reaction to tree nuts, peanuts Other food product: _____

Y/N Severe allergic reaction to bee sting, other insects: _____

Y/N Other severe allergies affecting school. Specify: _____

Y/N Severe asthma, regularly takes medication for asthmatic condition or hospitalized within last 5 years: _____

Y/N Seizure disorder: _____

Y/N Diabetes: _____

Y/N Heart condition: _____

Does your child have any of the following conditions that would affect his/her classroom performance or P.E. activities?

Y/N Allergies Specify: _____

Y/N Asthma, takes medication only when needed: _____

Y/N History of Seizure disorder: _____ Type & date of last seizure: _____

Y/N History of heart condition: _____

Y/N Digestive, bowel or bladder problems: _____

Y/N Growth problems: _____

Y/N Skeletal limitations: _____

Y/N Cancer/Leukemia: _____

Y/N Neuromuscular problems: _____

Y/N Other developmental disability: _____

Y/N Attention Deficit Disorder: _____

Y/N Behavioral/Emotional concerns: _____

Y/N Tourette's Syndrome: _____

Y/N Migraine headaches: _____

Y/N P.E. considerations: _____

Y/N Vision deficit: _____

Y/N Hearing loss: _____

Y/N Routine medication: _____

Medication: State law requires written permission from a Health Care Provider & parent before any medication (prescription or over-the-counter) can be carried by a student at school. A form is availible from the school nurse or office. This information is confidential. It will be shared with staff on a need-to-know basis. I understand 911 may be called to assist in a medical emergency during school hours. I understand that is my responsibility to notify the school office in writing if there is a change in my child's health.

Preferred Doctor: _____ Phone #: _____

Preferred Hospital: _____ Phone #: _____

Parent/Guardian Signature: _____ Date: _____

Confidential, please return this form to the permanent record file.