

Mercer Island School District
Student Health Form

Student Name: _____ Date of Birth: _____ Male: _____ Female: _____

School: _____ Grade: _____ Class of: _____

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. The MISD medication form and school nurse contact information is available on the school nurse web site: www.misd.k12.wa.us/parents/families/snews.

Does your child have any of the following conditions? Please explain:

No ___ Yes ___ Severe allergic reaction to tree nuts, peanuts: _____
Other food product: _____

No ___ Yes ___ Severe allergic reaction to bee stings, other insects: _____

No ___ Yes ___ Other severe allergies-affecting school. Specify: _____

No ___ Yes ___ Severe asthma, regularly takes medication for asthmatic condition or hospitalized within last 5 years: _____

No ___ Yes ___ Seizure disorder: _____

No ___ Yes ___ Diabetes: _____

No ___ Yes ___ Heart condition: _____

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

Please explain:

No ___ Yes ___ Allergies. Specify: _____

No ___ Yes ___ Asthma, takes medication only when needed: _____

No ___ Yes ___ History of seizure disorder: _____ Type and date of last seizure: _____

No ___ Yes ___ History of heart condition: _____

No ___ Yes ___ Digestive, bowel or bladder problems: _____

No ___ Yes ___ Growth problems: _____

No ___ Yes ___ Skeletal limitations: _____

No ___ Yes ___ Cancer/Leukemia: _____

No ___ Yes ___ Neuromuscular problems: _____

No ___ Yes ___ Other developmental disability: _____

No ___ Yes ___ Attention Deficit Disorder: _____

No ___ Yes ___ Behavioral/Emotional concerns: _____

No ___ Yes ___ Tourette's Syndrome: _____

No ___ Yes ___ Migraine headaches: _____

No ___ Yes ___ PE considerations: _____

No ___ Yes ___ Vision deficit: _____

No ___ Yes ___ Hearing loss: _____

No ___ Yes ___ Routine medication: _____

Medications: State law requires written permission from a Health Care Provider and parent before any medication (prescription or over-the-counter) can be given or carried by student at school. A form is available from the school nurse, office, or school nurse website: www.misd.k12.wa.us/parents/families/snews.

This information is considered confidential. It will be shared with school staff on a need-to-know basis. I understand 911 may be called to assist in a medical emergency during school hours. I understand it is my responsibility to notify the school office in writing if there are any changes in my child's health.

Preferred Doctor: _____ Phone number: _____

Preferred Hospital: _____ Phone number: _____

Parent/Guardian Signature: _____ Date: _____

CONFIDENTIAL.
Please return this form to school nurse.