Lake Washington School District

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Nurse Alert Form

Information on this form should be filled out/updated for each new school year. Please complete this form and return as soon as possible. In order to provide a safe and healthy environment for your child, this information will be reviewed by the school nurse and shared with staff. **Minor health conditions that will not affect your child at school do not need to be listed on this form.**

Student Name ______________________________ Birth date ______________
Last First Middle

School ______________________________ Grade __________ Teacher ______________________

Serious Health Conditions (check appropriate box below)

If your child has a serious health condition, it is vital that you discuss this with your school nurse immediately. **Washington state law (RCW 28A.210.320) requires that medication or treatment orders, medications and a health care plan be in place prior to the start of school. Your school nurse will work with you to develop a health plan for your child. Contact the school nurse through the school office.**

☐ **My child does not have any health conditions that will affect him/her at school.**
(If this box is checked, no further information is necessary. Please sign/date at bottom and return to school office.)

☐ **My child has the following serious health condition(s) – Check box(es) below:**

- ☐ **Asthma -** Will your child require an inhaler at school? __________ (Yes or No)
- ☐ **Cardiac diagnosis:** ______________________________
  Restrictions: ______________________________
- ☐ **Diabetes** (Date of diagnosis: ______________)
  - ☐ Insulin pump ☐ Independent
  - ☐ Insulin via pen ☐ Dependent
  - ☐ Insulin via syringe
- ☐ **Life threatening allergy** (Requires an EpiPen or Auvi-Q at school)
  Allergens: ______________________________
- ☐ **Seizure Disorder** (Type: ______________________________)
  Medication(s): ______________________________
- ☐ **Other serious health condition(s):** ______________________________

Medications (prescription, supplements, and over-the-counter)

All medications given at school require an **Authorization for Administration of Medication form** available at www.lwsd.org or at the school office. All prescription medications must be in the original container with a pharmacy label that matches the health care provider orders. Over-the-counter medications and supplements must be in the original container marked with the student's name.

Medication(s) to be given at school: ______________________ **Medication(s) taken at home:** ______________________

Emergency Preparedness for Medical/Dietary Conditions

We request that parents/guardians of students with serious medical/dietary conditions provide medication and/or appropriate food to be kept at school in case there is an emergency that would detain them at school. A three-day supply is requested.

Emergency Contact Information

Parent/guardian name ______________________________ Primary phone ______________________

Email address ______________________________ Secondary phone ______________________

Health care provider ______________________________ Phone number ______________________

Parent signature ______________________________ **Date** ______________________