

Kelso School District

Student Health Inventory

Student Last Name: _____ First Name: _____ Gender: Female Male

Date of Birth: _____ School: _____ Grade: _____

Physician's Name: _____ Physician's Phone Number: _____

Dentist's Name: _____ Dentist's Phone Number: _____

The purpose of this letter is to inform you of a law enacted in Washington State that will help your child's school provide for the safety and health of children during the school day. This law, Substitute House Bill 2834, Children with Life-Threatening Conditions, took effect June 13, 2002.

The law defines life-threatening condition as a "health condition that will put the child in danger of death during the school day if a medication or treatment order and a nursing plan are not in place." **Children with life-threatening conditions such as severe bee sting or severe food allergies, asthma, diabetes, seizure, etc., are now required to have a medication or treatment order and nursing plan in place BEFORE they start school. The medication or treatment order must be from the child's licensed health care provider.**

If a medication or treatment order is not provided, the chief administrator of the school is required to exclude the child until such order has been provided. This requirement applies to students with a life-threatening condition who are new to the district, and students who are already attending the school. Our exclusion procedures are in accordance with the rules (WACs) of the State Board of Education.

It is vital to your child's safety during the school day that if your child has a life-threatening health condition that may require medical services to be performed at school, you immediately notify your school's principal or healthcare specialist. The necessary forms will be provided and a time will be arranged for you to meet with your child's healthcare specialist.

Please speak with your building Health Specialist or District Nurse if you have any questions or would like further clarification.

Please Check All That Apply:

My child **DOES NOT** have any health concerns.

Severe Allergic Reaction (e.g. food, medication, etc.) Please specify: _____

Asthma Inhaler? Yes No Date last used: _____

Diabetes Type 1 Type 2 Managed by: Diet only Insulin injection Insulin pump

Seizure Disorder Type of seizure: _____ Date of last seizure: _____

Other Life-Threatening health concerns: _____

Other health concerns: _____

Parent signature

Date