

**RAINIER CHRISTIAN SCHOOLS - KENT VIEW ELEMENTARY
STUDENT HEALTH INFORMATION**

The following information is needed to plan and be prepared for any needs or emergency situation should one arise during school attendance.

Student Name _____ Birthdate _____ Grade _____ Campus _____ SEX: M F

****DATE OF LAST PHYSICAL:** _____ **ATTENDING PHYSICIAN:** _____

A. HEALTH HISTORY: Please describe any significant or chronic medical problems such as asthma, hay fever, diabetes, heart condition, seizure disorder, headaches, orthopedic, vision, surgeries, emotional problems, chronic colds or ear infections, speech difficulty, nose bleeds, etc.:

Diagnosis: _____

Date of Onset & Treatment: _____

Does student wear: Contact Lens: _____ Glasses: _____ Last eye exam: _____

B. ALLERGIC TO: Medications (name): _____ Foods: _____

Insects: _____ Plants: _____ Other: _____

Please describe the allergic reaction and necessary treatment: _____

C. MEDICATIONS: Please list medications (and dosages) your child takes on a regular basis:

Please describe the condition/disorder for which the above medication was prescribed:

D. Was there a health problem and/or handicap present at birth? Yes _____ No _____

At what age was diagnosis made? _____ Diagnosis: _____

Physicians or agencies which made diagnosis: _____

Physical Education activity: Limited _____ Not limited _____

If activity is to be limited, please explain _____

E. EMERGENCY INFORMATION: In sequence, PARENT TO BE NOTIFIED in case of emergency:

1. _____ Phone: () _____

2. _____ Phone: () _____

F. PERSON TO BE NOTIFIED if parent/guardian cannot be reached:

1. _____ Phone: () _____

Relation: _____

2. _____ Phone: () _____

Relation: _____

G. MEDICAL Insurance Provider: _____ Family Physician: _____ Phone: _____

Group/Membership #: _____ Address: _____

Family Dentist: _____ Phone: _____

Address: _____

MEDICAL AND/OR EMERGENCY RELEASE:

In the event of an emergency and all attempts to reach me have failed, and school authorities judge that immediate observation and/or treatment is necessary, I authorize and direct that my child receive such care as is necessary. Emergency treatment may require notification of an Emergency Aid Unit (9-1-1). Further treatment, based upon Medical evaluation and recommendation, may be given. I understand that I assume responsibility for any payment of services rendered if required.

Date: _____

Signature of Parent/Guardian

PERMISSION TO ADMINISTER MEDICATION:

I understand that in the event my child needs to take Over-The-Counter or Prescription Medication, I must complete the "Authorization for Administration of Oral Medication at School" form.

Date: _____

Signature of Parent/Guardian