

Special Health Considerations:

If any of the following conditions or other special medical considerations apply, please contact the head of school to create an individualized healthcare plan.

Medication:

Does your child take any medication? Yes _____ No _____

Is medication needed at home? Yes _____ No _____ Name of medication _____

Is medication needed at school? Yes _____ No _____ Name of medication _____

***Students requiring medication (prescription or non-prescription) at school MUST have a written order by a licensed health care professional and written parent consent. See additional Authorization for Administration of Medication at School.**

Attention Deficit Disorder:

Medication at school *see instructions below Medication at home Diagnosed, un-medicated

Anaphylaxis:

If your child has an anaphylactic allergy as indicated on the reverse side of this form, please answer the following questions:

1. What is your child allergic to? _____
2. What are your child's symptoms? _____
3. Has your child been prescribed an Epi-pen? _____

Diabetes

There is a state law which requires all students with diabetes to have an individualized health care plan implemented in the school setting. If your child is diabetic, please contact the head of school to help write this plan.

Asthma:

If your child has asthma as indicated on the reverse side of this form, please circle what applies below the following questions:

Intermittent - Symptoms of wheezing and coughing no more than 2 days a week, with nighttime flare-ups twice a month or less. Outside of these few episodes, free of symptoms.

Mild – Symptoms occur more than twice a week but less than once a day, flare-ups may affect activity.

Moderate – Symptoms occur daily, flare-ups usually last several days. Symptoms disrupt normal activities and make it difficult to sleep.

Severe – Symptoms occur daily and often, also curtail the student's activities and disrupt sleep. Inhaler/medications needed at school.

Please check Yes or No to the following:

Uses Inhaler Yes _____ No _____

Exercise Induced Yes _____ No _____

Life Threatening Conditions

IF ANY OF THE ABOVE HEALTH CONDITIONS ARE LIFE-THREATENING, RCW 28A.210 requires that physician orders, medications, and/or treatments and a care plan must be in place before a student attends school.

Authorization for Emergency Medical Treatment

I understand that the information given above will be shared with appropriate school staff to provide for the health and safety of my student. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most accessible hospital or physician. I understand that full responsibility for payment and any transport or emergency medical services rendered is with me. I understand that Explorations Academy, its employees, and Board of Directors assume no liability of any nature in relationship to the transportation or treatment of said minor.

***IT IS VERY IMPORTANT THAT YOU INFORM EXPLORATIONS ACADEMY OF ANY CHANGES IN YOUR STUDENT'S HEALTH THAT MAY OCCUR THROUGHOUT THE SCHOOL YEAR.**

Parent/Guardian Signature _____

Date _____