P-134 (Letter)
2/11

EDMONDS 15 SCHOOL DISTRICT

EDMONDS SCHOOL DISTRICT

STUDENT SERVICES

20420 68th Ave. W., Lynnwood, WA 98036-7400
425-431-7000 FAX 425-431-7339

Includes Brier, Edmonds, Lynnwood, Mountlake Terrace and Woodway

Dear Parents/Guardians:

The purpose of this letter is to inform you of a Washington State Law, "Children with Life-Threatening Conditions," (RCW 28A, 210 320), that will help your student's school provide for the safety and health of students during the school day.

The law defines life-threatening condition as "a health condition that will put the student in danger of death during the school day if a medication or treatment order and a nursing plan are not in place." Students with life-threatening conditions such as severe bee sting or severe food allergies, severe asthma, diabetes, severe seizures, or other at-risk conditions are required to have a medication or treatment order and a nursing plan in place before they start school. The medication or treatment order must be from the student's licensed health care provider (LHP), who may be a doctor, physician's assistant, advanced registered nurse practitioner, etc.

To protect your students health and safety at school, if a medication or treatment order is not provided, the principal of the school is required to exclude the student until such an 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. Exclusion procedures are guided by the state mandated rules of the State Board of Education.

If your student has a life-threatening health condition that may require medical services to be performed at school, you need to immediately notify your school's principal and school nurse. The necessary forms will be provided and a time will be arranged for you to meet with your student's school nurse.

Please call your school's main office if you have any questions or would like further clarification.

P-134 att. 2/11

EDMONDS SCHOOL DISTRICT NO. 15

Registration Attachment

PLEASE PRINT CLEARLY

School _____ Grade Level _____ Date _____

Student Name _____ Date of Birth _____

Expected student school start date: _____ Parent/Guardian Name (Print)_____

The following information is important for your student's health and safety. It will be forwarded to the school nurse.

I acknowledge that this information will be maintained in my student's school record and shared with staff on a need to know basis to provide a safe and healthy environment for my student.

❑ **I prefer to speak with a school nurse directly regarding my child's health information described below.**

Please contact me by telephone at this number: (_____)_____

Health Information

Does your child have a **LIFE-THREATENING HEALTH CONDITION**? ❑ Yes ❑ No

A **LIFE-THREATENING CONDITION** is 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, severe asthma, diabetes, severe seizures, or other at-risk conditions are required to have a medication or treatment order and a nursing plan in place before they start school. Please notify office staff at registration; you will need to contact your school nurse before your student can attend school.

Does your student have medical insurance? ❑ Yes ❑ No If so, what kind? _____

Has your child ever been hospitalized for a health condition? ❑ Yes ❑ No If so, what kind? _____

Check any of these conditions which your child has or has had:

❑ ADD	❑ Blood Disorder	❑ Convulsions/Seizures	❑ Hearing Problems	❑ Orthopedic/Bone
❑ ADHD	❑ Bowel Concerns	❑ In Counseling	❑ Heart Disease	❑ Social/Emotional/Behavioral
❑ Autism	❑ Cancer	❑ Diabetes	❑ Kidney/Bladder Disease	❑ Vision Problems

❑ Allergy to: _____ Severe? ❑ Yes ❑ No

❑ Asthma Severe? ❑ Yes ❑ No Hospitalized for asthma? ❑ Yes ❑ No What triggers your student's asthma (for example: exercise, upper respiratory infections, allergies, emotions, etc.)? _____

_____

❑ Other heath concerns: (please specify) _____

Licensed health provider name: (e.g. M.D., D.O., A.R.N.P., P.A., etc.) Name: _____

Contact phone number: (_____)_____

What does this student do to manage his/her own condition? _____

_____

How can the nurse/teacher help with this at school? _____

_____

What symptoms should we report to you? _____

_____

List any medications taken by student.

Medication Taken: _____ For _____ ❑ At Home ❑ At School

Medication Taken: _____ For _____ ❑ At Home ❑ At School

Students who have medication administered by school staff need an **MEDICATION AUTHORIZATION** form completed and signed by their attending health care provider and parent or legal guardian. You can obtain this form from the school office staff.

Provide any information not included above which you think we should know about this student's physical, emotional, or mental health which might affect school performance or require special consideration (i.e. limitations in activities, major life events, etc.).

_____

_____

Signature of Parent/Legal Guardian _____ Date _____

Permission for hearing test?
❑ Yes ❑ No

✉ White: Nurse Yellow: File