SUMMIT CHRISTIAN ACADEMY
SPECIAL HEALTH CONDITIONS

Dear Parent,
Please describe your child's current health condition on the form below. It is important that you keep the school informed of any changes in health or medication which would affect your child at school. If your child needs to take medication at school, please notify the school office.

☐ **CHECK HERE IF ANY OF THE HEALTH CONDITIONS ARE LIFE THREATENING AND WOULD REQUIRE EMERGENCY MEDICATION OR TREATMENT AT SCHOOL. Please circle the condition(s) that are life threatening.**
RCW 28A.210 requires that physician orders and a nursing care plan must be in place before a student attends school.

☐ The health condition(s) I have described below is/are of sufficient concern that I will contact the school nurse at the enrolling school.

CURRENT HEALTH CONDITIONS

ASTHMA	Medications needed AT school: □ Yes** □ No (**Physician's orders & nursing care plan required)
BLOOD DISORDER Anemia, Hemophilia, etc.	Type: Accommodations:
CARDIAC	Type: Limitations:
*DIABETES	□ Type 1** (**Physician's orders & nursing care plan required) □ Type 2 Medications:
EATING/SWALLOWING DIFFICULTIES (Notify Speech Language Pathologist)	Describe: Accommodations:
DIGESTIVE DISORDER Food intolerance, colitis, etc.	Type: Food substitutions needed: □ Yes** □ No (** Diet prescription form required)
HEARING IMPAIRMENT OR COMPLETE LOSS	Describe: Accommodations:
INSECT STING ALLERGY	Insect Type: Life threatening reaction: □ Yes** □ No (**Physician's orders, nursing care plan & medication required)
LATEX ALLERGY	Accommodations: Life threatening reaction: □ Yes** □ No (**Physician's orders, nursing care plan & medication required)
SKIN PROBLEMS Eczema, etc.	Describe: Accommodations:
*IMMUNOSUPRESSION Cancer, transplant, etc.	Type: Accommodations:
NEUROLOGICAL PROBLEM Hydrocephalus, Cerebral Palsy, etc.	Type: Accommodations:
ORTHOPEDIC PROBLEM Arthritis, Muscular Dystrophy, etc.	Type: Limitations: □ Yes** □ No (**Physician's note required)
BEHAVIORAL/MENTAL HEALTH ADHD, Autism, Depression, Anxiety, etc.	Type: Medications needed **AT** school: □ Yes** □ No (**Physician's orders required)
RESPIRATORY PROBLEM Cystic Fibrosis, etc.	Type: Medications needed **AT** school: □ Yes** □ No (**Physician's orders required)
*SEIZURE DISORDER Epilepsy, etc.	Type: Accommodations:
URINARY/KIDNEY DISORDER Nephritis, etc.	Type: Accommodations:
VISION IMPAIRMENT OR COMPLETE LOSS	Describe: Accommodations:
DRUG ALLERGY	Type:
OTHER HEALTH PROBLEMS	Describe: Accommodations:

☐ **No health problems to my knowledge**

*** Notification of school nurse required**

**** Additional information required (Physician's orders, nursing care plan and/or medication)**

_____	_____	_____
Date	Parent/Guardian Signature	Full Name