Washington State School for the Blind
2214 E. 13th St. · Vancouver, Washington 98661-4120
(360) 696-6321 · FAX # (360) 737-2120

Health Center Guardian Consent and Health Questionnaire

This form must be completed at the beginning of each school year annually. Please read each section thoroughly and mark all appropriate boxes. Please do not leave a section blank.

PLEASE NOTE: WSSB Nurses are not able to administer prescription medications to students without the Medical Evaluation for School Attendance and School Sports form properly completed and signed.

Student Name

Date of birth

Gender assigned at birth

Gender identity

Guardian Name

Phone

Email

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1. Medical Information, Treatment, & Communication

	Comments
Does your student have any medical conditions or life-threatening health conditions, such as asthma, epilepsy, anaphylaxis, diabetes or a shunt? ☐ Yes ☐ No	
Is your student at risk for retinal detachment? ☐ Yes ☐ No	
Does your student have a life threatening allergy? ☐ Yes ☐ No	
Local licensed healthcare providers and licensed healthcare providers contracted by WSSB may provide urgent medical care as needed. (Non-urgent care should continue at home.) ☐ Yes ☐ No	
Nurses may provide appropriate level of care. ☐ Yes ☐ No	
Nurses may convey student's health and medical information that will be kept confidential, as they perceive beneficial, to staff working with my student. ☐ Yes ☐ No	
Does your student have any dietary restrictions or special diets? ☐ Yes ☐ No	
Does the student have any activity restrictions? ☐ Yes ☐ No	
WSSB nurses may test my student for COVID 19, Influenza and/or Strep A as needed. ☐ Yes ☐ No	

_____ _____

Guardian Signature Date

2. Over-the-Counter Medication Administration

Please note: WSSB Nurses have a comprehensive list of medication standing orders to administer to students. Without a signed medical face sheet, acetaminophen (Tylenol), ibuprofen (Motrin), diphenhydramine (Benadryl), antacids, and cough syrup are the only over-the-counter medications to be given.

WSSB nurses and delegated staff may administer over-the-counter medications and prescription medication prescribed by a licensed healthcare provider.

☐ Yes ☐ No

Does your student have over-the-counter medication restrictions?

☐ Yes ☐ No

Please note medication(s) your student CANNOT have:

Guardian Signature _____ Date _____

3. Regularly Scheduled Prescription/Over-the-Counter Medications

My student will take a regularly scheduled prescription medication while at WSSB. If Yes, student's primary care provider will need to complete the medical evaluation for school attendance and School Sports Form.

☐ Yes ☐ No

My student will take a prescription medication, as needed, for a specific condition while at WSSB. (E.G. migraine headaches).

☐ Yes ☐ No

My student will take a regularly scheduled over-the-counter medication while at WSSB.

☐ Yes ☐ No

Please Note: Medication MUST be provided to WSSB nurses in original, properly labeled containers per RCW 28A.210.260(6) Medication will not be accepted in baggies, weekly pill containers, etc. and student may not be allowed to reside on campus until properly labeled medication is provided.

Guardian Signature _____ Date _____

4. Medication - Other

I feel that my student is capable of safely transporting his/her medication should a monitor not be available to transport. (For example, students who fly home or take the train).

☐ Yes ☐ No

I agree to inform the Health Center of medication sent, amount, and reason for the medication.

☐ Yes ☐ No

I give consent for my student to participate in the WSSB Nurse Supervised Self-Directed Medication Program. More information on this program can be requested from the Health Center.

☐ Yes ☐ No

Authorization For Administration Of Medications At WSSB

As the legal guardian of _____ I request that medication be administered to my child by a member of the WSSB staff in accordance with my licensed care provider instructions.

Medication will be administered at WSSB or on WSSB sanctioned field trips. I will notify the school immediately if I change licensed care providers or if the medication or dosages change.

I agree to provide WSSB nurses with prescription and over-the-counter medication that is properly labeled with the following information: date, name of student, name of medication, dosage, reason for needing medication, amount of medication being provided, method of administration, time to be given, side effects to watch for, signature of guardian and signature of licensed care provider.

I understand that medication not provided in the original and appropriate labeled containers, will not be given to the student. The student may not be able to reside at WSSB until medications are provided with proper labeling.

_____ _____

Guardian Signature Date

5. Health Questionnaire

General Questions

1. Has a doctor ever denied or restricted your student's sports activity for any reason?

☐ Yes ☐ No ☐ Unsure

2. Does your student have any ongoing medical conditions?

☐ Yes ☐ No ☐ Unsure

If Yes, please identify below:

☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections ☐ Other:

3. Has your student ever spent the night in the hospital?

☐ Yes ☐ No ☐ Unsure

4. Has your student ever had surgery?

☐ Yes ☐ No ☐ Unsure

Heart Health Questions About Your Student

5. Has your student ever passed out or nearly passed out DURING or AFTER exercise?

☐ Yes ☐ No ☐ Unsure

6. Has your student ever had discomfort, pain, tightness, or pressure in the chest during exercise?

☐ Yes ☐ No ☐ Unsure

7. Does your students heart ever race or skip beats during exercise?

☐ Yes ☐ No ☐ Unsure

8. Has a doctor ever told your student that they have any heart problems?

☐ Yes ☐ No ☐ Unsure

If Yes, check all that apply:

☐ High blood pressure ☐ High cholesterol ☐ Kawasaki disease
☐ A heart murmur ☐ A heart infection ☐ Other:

9. Has a doctor ever ordered a test for your student's heart? (For example, ECG/ EKG, echocardiogram)

☐ Yes ☐ No ☐ Unsure

10. History of feeling lightheaded or more short of breath than expected during exercise?

☐ Yes ☐ No ☐ Unsure

11. Has your student ever had an unexplained seizure?

☐ Yes ☐ No ☐ Unsure

12. History of being more tired or short of breath compared to friends during exercise?

☐ Yes ☐ No ☐ Unsure

Heart Health Questions About Your Students Family

13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?
☐ Yes ☐ No ☐ Unsure

14. Does anyone in your student's family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?
☐ Yes ☐ No ☐ Unsure

15. Does anyone in your student's family have a heart problem, pacemaker, or implanted defibrillator?
☐ Yes ☐ No ☐ Unsure

16. Has anyone in your student's family had unexplained fainting, unexplained seizures, or unexplained near drowning?
☐ Yes ☐ No ☐ Unsure

Bone & Joint Questions

17. History of injury to bone, muscle, ligament, or tendon that caused your student to miss a practice or a game?
☐ Yes ☐ No ☐ Unsure

18. Has your student ever had any broken or fractured bones or dislocations?
☐ Yes ☐ No ☐ Unsure

19. Has your student ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?
☐ Yes ☐ No ☐ Unsure

20. Has your student ever had a stress fracture?
☐ Yes ☐ No ☐ Unsure

21. Has your student ever been told they have neck instability or atlantoaxial instability?
☐ Yes ☐ No ☐ Unsure

22. Does your student regularly use a brace, orthotics, or other device?
☐ Yes ☐ No ☐ Unsure

23. Does your student have a bone, muscle, or joint injury?
☐ Yes ☐ No ☐ Unsure

24. History of swollen or painful joints?
☐ Yes ☐ No ☐ Unsure

25. Any history of juvenile arthritis or connective tissue disease?
☐ Yes ☐ No ☐ Unsure

Medical Questions

26. Does your student cough, wheeze, or have difficulty breathing during or after exercise?
☐ Yes ☐ No ☐ Unsure

27. Has your student ever used an inhaler or taken asthma medicine?
☐ Yes ☐ No ☐ Unsure

28. Is there anyone in the family who has asthma?
☐ Yes ☐ No ☐ Unsure

29. History of missing a kidney, eye, a testicle, spleen, or any other organ?
☐ Yes ☐ No ☐ Unsure

30. Does your student have groin pain, painful bulge, hernia in the groin?
☐ Yes ☐ No ☐ Unsure

31. History of infectious mononucleosis (mono) within the last month?
☐ Yes ☐ No ☐ Unsure

32. History of rashes, pressure sores, or other skin problems?
☐ Yes ☐ No ☐ Unsure

33. History of herpes or MRSA skin infection?
☐ Yes ☐ No ☐ Unsure

34. History of a head injury or concussion?
☐ Yes ☐ No ☐ Unsure

35. History of a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
☐ Yes ☐ No ☐ Unsure

36. Does your student have a history of seizure disorder?
☐ Yes ☐ No ☐ Unsure

37. Does your student have headaches with exercise?
☐ Yes ☐ No ☐ Unsure

38. History of, tingling, weakness in your arms or legs after being hit or falling?
☐ Yes ☐ No ☐ Unsure

39. Has your student ever been unable to move your arms or legs after being hit or falling?
☐ Yes ☐ No ☐ Unsure

40. History of becoming ill while exercising in the heat?
☐ Yes ☐ No ☐ Unsure

41. History of frequent muscle cramps when exercising?
☐ Yes ☐ No ☐ Unsure

42. Family history of sickle cell trait or disease?
☐ Yes ☐ No ☐ Unsure

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43. History of any eye injuries?
☐ Yes ☐ No ☐ Unsure

44. Does your student wear glasses or contact lenses?
☐ Yes ☐ No ☐ Unsure

45. Use of protective eyewear, such as goggles or a face shield?
☐ Yes ☐ No ☐ Unsure

46. Does your student worry about their weight?
☐ Yes ☐ No ☐ Unsure

47. Has student been advised to gain or lose weight?
☐ Yes ☐ No ☐ Unsure

48. Any special diet or do avoidance of certain types of foods?
☐ Yes ☐ No ☐ Unsure

49. History of eating disorder?
☐ Yes ☐ No ☐ Unsure

50. Has your student ever had a menstrual period?
☐ Yes ☐ No ☐ Unsure ☐ Not Applicable

51. Age at first menstrual period?
☐ Not Applicable

52. How many periods in the last 12 months?
☐ Not Applicable

Additional Explanations of yes answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Guardian Signature _____ Date _____