WISHRAM SCHOOL

Wishram School District #94
P.O. Box 8
Wishram, WA 98673
(509) 748-2551
(509) 748-2127 (fax)

REQUEST FOR PUPIL'S RECORDS

TO: _____ DATE: _____
School

_____
Address

_____
City, State, Zip

RE: _____ _____ _____
Student's Name Date of Birth Current Grade

THE ABOVE NAMED STUDENT HAS ENROLLED IN OUR SCHOOL. PLEASE FORWARD TO US THE RECORDS LISTED BELOW, TO THE EXTENT THAT THEY EXIST:

Thank you,

_____
Registrar's Signature

* Permanent Record
* Health Record File
* Special Education Records
* Withdrawal Grades
* Certificate of Immunization
* Physical Exam
* Behavioral Records

I hereby give my permission for any and all of my child's records, including confidential records, to be sent to:

Wishram School
P.O. Box 8
Wishram, WA 98673

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

STUDENT HEALTH REGISTRATION FORM & CONSENT FOR EMERGENCY MEDICAL TREATMENT 2022-2023

Student Name: _____ Date of Birth: _____ Grade: _____ Gender: _____
Physical address: _____
Mailing address (if different): _____

Father's Name: _____ Cell Phone: _____ Email: _____
Father's mailing address (if different): _____
Father's Employer: _____ Work phone: _____

Mother's Name: _____ Cell Phone: _____ Email: _____
Mother's mailing address (if different): _____
Mother's Employer: _____ Work phone: _____

Emergency Contact: _____ Relationship: _____ Phone number: _____
Emergency Contact: _____ Relationship: _____ Phone number: _____

Doctor: _____ Phone: _____ Dentist: _____ Phone: _____
Preferred Hospital: _____ Medical insurance: _____ Policy #: _____

PLEASE CIRCLE ANY LIFE-THREATENING CONDITIONS

State Law, RCW 28A.210 requires that students with life-threatening health conditions must have physician orders and a nursing care plan before attending school. This information may be shared with school district staff that have a "need to know," in order to provide a healthy, safe environment.

☐ NO KNOWN HEALTH CONCERNS	
RESPIRATORY PROBLEMS: Asthma, cystic fibrosis, etc.	Severity: Special needs/medications:
SEVERE ALLERGY TO: Food, insects, medication Life-threatening: ☐ Yes ☐ No	Allergen/ reaction: Medications needed:
SEIZURE DISORDER: Epilepsy etc.	Type: Special needs/medications:
A.D.D./ A.D.H.D (circle one)	Special needs/medications:
DIABETES	Type: Special needs/medications:
NEUROLOGICAL CONDITION: Hydrocephalus, cerebral palsy, etc.	Type: Medication needed:
HEART CONDITIONS	Type: Special needs:
ORTHOPEDIC PROBLEMS: Arthritis, scoliosis, braces, wheelchair	Type: Surgeries/limitations:
CANCER, LEUKEMIA, TUMORS	Type: Special needs/medications:
DIGESTIVE PROLEMS: Ulcers, colitis, etc.	Type: Special needs/medications:
URINARY/KIDNEY DISORDER	Type: Special needs/medications:
VISION/HEARING PROBLEMS OR COMPLETE LOSS OF	Type: Special needs/contacts/glasses/hearing aids
SERIOUS ILLNESS, INJURIES, OPERATIONS	Type: Special needs:
OTHER DIAGNOSED HEALTH PROBLEMS	Type: Special needs:

IF MEDICATIONS ARE NEEDED AT SCHOOL PLEASE CONTACT THE SCHOOL OFFICE FOR APPROPRIATE FORMS

I will keep the school health services informed throughout the year regarding any changes in health status and/or contact information. I understand that if either parent/guardian or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize the school staff to request emergency medical services (911). I understand I may be responsible for the payment of any medical services if needed.

Parent/guardian signature: _____ Date: _____

WISHRAM SCHOOL DISTRICT #94

8/30/2022

To: Parents and Guardians

From: Guy Strot, Superintendent / Principal

Subject: COVID TESTING

As we continue to navigate the COVID-19 pandemic, Wishram School District will still be providing on site testing.

In order to offer this service, we need consent from parents/guardians. By signing this form, you are authorizing Wishram School District #94 to provide COVID-19 testing to your student should they show symptoms of an active infection, or if they have potentially been exposed to individuals who have tested positive. These tests are **not** invasive, and our staff will be provided with requisite training to carry out on-site testing. The individual that needs to be tested will swab the inside of their own nose to a depth of around an inch, and then the sample will be monitored for 15 minutes until a result is present.

We appreciate your continued cooperation as we continue to do our best to keep our students and staff safe. Please call or email myself or Ronni Orton-Blodgett, at the school 509-748-2551, with any questions or concerns.

Student Name(please print)_____

Student Date of Birth_____

Parent Name (please print)_____

Parent Signature_____ Date_____

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