



# Washington School for the Deaf

## Post High School Application Packet

Post High School Program  
Washington School for the Deaf  
611 Grand Blvd / Vancouver, WA 98661  
(360) 696-6525 (V/TTY) / (800) 613-4228 / [www.wsd.wa.gov](http://www.wsd.wa.gov)



Please describe your health problems on the form below. It is important that you keep the school informed of any changes in health or medication which would affect your performance. If you need to take medication at school, please notify the school nurse.

The health condition that I have described below is of sufficient concern that I would like to consult with the school nurse, I therefore agree to contact the school nurse at (360) 696-6525 ext. 4333 or (800) 613-4228 ext. 4333.

ASTHMA	Type:
	Special Needs:
BLOOD DISEASE Anemia, Hemophilia, etc.	Type:
	Special Needs:
CARDIAC	Type:
	Special Needs:
DIABETES	Medication:
	Special Needs:
SEVERE FOOD ALLERGY	Type:
	Special Needs:
DIGESTIVE DISORDER Food Intolerance, etc.	Type:
	Special Needs:
HEARING IMPAIRMENT OR COMPLETE LOSS	Describe:
	Special Needs:
INSECT STING ALLERGY	Type:
	Describe reaction:
MALIGNANCY	Type:
	Special Needs:
NEUROLOGICAL PROBLEM Hydrocephalus, Cerebral Palsy	Type:
	Special Needs:
ORTHOPEDIC PROBLEM Arthritis, Muscular Dystrophy, etc.	Type:
	Surgeries:
	Limitations:
RESPIRATORY PROBLEM Cystic Fibrosis, etc.	Severity:
	Medication:
	Special Needs:
SEIZURE DISORDER Epilepsy, etc.	Type:
	Medication:
	Special Needs:
URINARY/KIDNEY DISORDER Nephritis	Type:
	Special Needs:
VISION IMPAIRMENT OR COMPLETE LOSS	Describe:
	Special Needs:
DRUG ALLERGY	Medication:
	Special Needs:
SERIOUS ILLNESSES/INJURIES	Describe:
	Special Needs:
SKIN PROBLEMS Eczema, etc.	Describe:
	Special Needs:
VISION PROBLEMS	Glasses:
	Contact Lenses:
OTHER HEALTH PROBLEMS	Describe:
	Special Needs:

None of the above to my knowledge

CHECK HERE IF ANY OF THE ABOVE HEALTH CONDITIONS ARE LIFE THREATENING.

If so, state law requires that medication/treatment orders and a nursing plan be in place before you may participate in the PHSP (RCW 28A.210 Sec. 1).

Signature

Date

Student Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex M [ ] F [ ]

Allergies \_\_\_\_\_ Date of Last Tetanus Shot \_\_\_\_\_

Medical Care

This is to authorize the Washington School for the Deaf medical staff and/or other doctors so designated to provide medical treatment and administer anesthetic by qualified personnel if it becomes necessary. The Washington School for the Deaf staff has the right to give first aid treatment to any student, and to seek and retain medical emergency or rescue services to treat, transport and/or hospitalize a student.

The student is responsible for providing payment or medical insurance coverage including medical expenses, evacuation and/or emergency transportation charges. Washington School for the Deaf does not provide medical insurance coverage for students and will not held responsible for medical expenses under any circumstance.

List any medications you are currently taking:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



Signature

Date

STUDENT INFORMATION				
STUDENT'S NAME		LAST	FIRST	MIDDLE INITIAL
ADDRESS		STREET	CITY	STATE ZIPCODE
HOME TELEPHONE	BIRTHDATE	AGE	SEX	EMAIL
INSURANCE INFORMATION				
NAME & ADDRESS OF INSURANCE COMPANY				
POLICY & GROUP NUMBERS/MEDICARE/UNION AND LOCAL			MY INSURANCE IS THROUGH _____ Employment _____ Private	
NAME & ADDRESS OF INSURANCE COMPANY				
POLICY & GROUP NUMBERS/MEDICARE/UNION AND LOCAL				
EMERGENCY CONTACT				
PLEASE LIST IN ORDER WHO YOU WOULD LIKE US TO CONTACT IN THE CASE OF AN EMERGENCY				
1				Relationship Phone
2				Relationship Phone
3				Relationship Phone
4				Relationship Phone