CONFIDENTIAL

LRSD Health Information

Student ID

Student's Name	Date of Birth	Grade	Parent Contact #

Health Diagnosis

Check all that apply (include date diagnosed):

- ADHD/ADD ☐
- Asthma (Asthma Action Plan REQUIRED) ☐
- Diabetes ☐
- Heart Disease ☐
- Kidney Disease ☐

Seizures--Date of most recent SEIZURE:

Past Surgeries

________________ ________________ Date:________

________________ ________________ Date:________

Other Diagnosis(es)

Allergies

(list known allergies for each category)

Check here if no known allergies ☐ No allergies

Seasonal Allergies:

Food Allergies:

Dietary Form and Food Allergy Plan must be completed by child's doctor and returned to school nurse before nutrition modifications may be made.

Epi-Pen provided ☐ Yes ☐ No

Drug Allergies

Other Allergies:

Behavioral/Mental/Emotional Concerns

Diagnosis

Physician

Therapist

Permission is granted to give the following medications in an emergency situation only: Epinephrine, Benadryl, Albuterol.

☐ yes ☐no

Medications

All medication must be given at home unless it is given more than 3 times per day or at a specific time as indicated on the prescription bottle. **No over the counter (OTC) medications will be given.**

Home Medications, dosage, and date began taking

1. Date
2. Date
3. Date

School Medications, dosage, and date began taking (must complete consent form at school)

1. Date
2. Date

Potential side effects from medications:

Required Health Procedures or Special Services

IMPORTANT: Doctor must fill out Individual Health Plan form (available in office) and procedures must be in place before student's first day of school.

List procedures

Insurance/Health Care Provider Info

ARKids/Medicaid (circle one) Yes No
If yes, please give ID number

Private Insurance (circle one) Yes No
If yes, insurance company name

Check here if your child does not have Health Insurance ☐ No Health Insurance

Eye Doctor/Ophthalmologist ____________________

Does student wear glasses? Yes No
If yes, for reading only? Yes No
Does child wear contacts? Yes No

Dentist

Doctor and/or Clinic Phone Number

Preferred Hospital

Parental Consent

I give consent for emergency medical treatment. I understand that I will be responsible for payment of any and all medical care services, including but not limited to emergency care that is not covered by the student's health insurance. I give consent for this information to be shared with my child's teacher and appropriate school staff.
I certify all information given is correct.

Parent Signature: Date: