Lewis-Palmer School District 38

Health Information Form

(Must be completed annually)

School Year ___________

Student's Name:_____________________ Birthdate _______________ Grade _________
Parent Name(s): ____ Preferred Hospital __________________________

CHECK all CURRENT conditions listed below for your child			
ADD/ADHD	Blood Disorder	Diabetes (pen/pump/CGM)	Migraines
Allergies	Bone/Joint	Developmental Delays	Seizures Type____________________
Asthma	Bowel/Bladder	Head Injury/Concussion	Stomach
Autism	Depression	Hearing Loss	Other: ________________________

Please describe above marked conditions:

Please list any CURRENT medical diagnosis:

Is your child taking any routine medications? **YES** **NO**
If **YES**, please list: Med Name/Dose/Time Taken ____
Med Name/Dose/Time Taken ____
Will your child take medication at school? **YES** **NO**
Will your child self-carry any meds at school? (Prescription and/or OTC, 7-12th grades ONLY) **YES** **NO**
(Please note: District 38 **requires** all students requiring medication to be given and/or self-carried at school, to have the Permission to Administer Medication Form on file and renewed each school year signed by healthcare provider, parent and student if student is self-carrying.)

Does your child have any Life Threatening Allergies that school staff need to know about? **YES** **NO**
If YES, please list allergy, reaction and date (month/year) of last reaction_________________________________
I WILL or **WILL NOT** be providing school rescue medication such as epinephrine for severe allergy listed above.
I understand 911 will be called should an emergency arise.

Does your child have any dietary restrictions? **YES** **NO** Please list: ____________________________________
If YES, is restriction related to Food Allergy **YES** **NO** Parent/Student preference **YES** **NO**

Does your child wear glasses **YES** **NO** Contacts **YES** **NO** Have a known color vision defect **YES** **NO**
Date of last vision exam (Month/Year) ___________ Eye Care Professional Name ______________________________

Hospitalizations and/or surgeries (Month/Year/Description) ____
____
____

Student's Physician Name/Address/Phone: ____
Student's Dentist Name/Address Phone: ____

Medicaid? **YES** **NO** Student's Health Insurance Company: ____

I give permission for this information to be shared with adults in school setting who will be working with my child on a need-to-know basis. It is the responsibility of the parent to notify the school nurse whenever there is any change in student's health status or care and ascertain any health information faxed/electronically sent to school by any outside sources have been received by the school

Form Completed by (Please Print): _________________________________ Relationship to student: _______________

Parent/Guardian signature: ____________________________________ Date: ____________________________

Updated 12/2017