LSDVI STUDENT HEALTH CENTER

HEALTH INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN EACH SCHOOL YEAR

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE. Parent/Legal guardian is encouraged to participate in the development of your child's Health Care Plan. Please use additional sheets, if necessary, for further explanation.

Name of School:	Grade:

Student's Name: Last First M.I.

Student's Date of Birth:	Sex: ☐ Male ☐ Female	State or Country of Birth:

Name of child's pediatrician or primary care provider (PCP):

Names of medical specialists or special clinics caring for your child:

Please check the type of health insurance your child has: ☐ None

☐ Private (Plan #/Provider's Name:_____)

☐ Medicaid (Plan# / Provider's Name:_____)

PART 2: COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD. Parent / Legal guardian is responsible for providing the school with any medication and may be responsible for providing the school with any special food or equipment that the student will require during the school day. Check with the school nurse to obtain correct medication and procedure forms.

ALLERGIES ☐ No ☐ Yes (if yes, please complete)

Allergy Type:

☐ Food (list food(s)):

☐ Insect sting (list insect(s)):

☐ Medications / Other (list):

Reactions: (if yes, date of last occurrence)

☐ Difficulty Breathing (Date:) ☐ Local Swelling (Date) ☐ Rash (Date:)

☐ Wheezing (Date:) ☐ Coughing (Date:) ☐ Nausea (Date:)

☐ Generalized swelling (Date:) ☐ Hives (Date:) ☐ Other (Date:)

ASTHMA ☐ No ☐ Yes (if yes, please complete)

Triggers:

☐ Environmental (i.e., tobacco, dust, pets, pollen, etc.), please list:

☐ Other (list):

Does your child experience asthma symptoms with exercise? ☐ No ☐ Yes

Symptoms:

☐ Chest tightness, discomfort, or pain ☐ Difficulty breathing ☐ Coughing ☐ Wheezing ☐ Other:

Date of last hospitalization related to asthma:

Date of last emergency room visit related to asthma:

Does your child have a written asthma management plan? ☐ No ☐ Yes

Is peak flow monitoring used? ☐ No ☐ Yes

Diabetes ☐ No ☐ Yes (if yes, please complete)

Currently prescribed medications and treatments:

☐ Insulin: ☐ Syringe ☐ Pen ☐ Pump

☐ Blood sugar testing: ☐ Frequency:

☐ Glucagon (if yes, please state parameters for its use):

☐ Oral medication (s) (list):

SEIZURE DISORDER ☐ No ☐ Yes (if yes, please complete)

Type of Seizure:

☐ Absence (staring, unresponsive) ☐ Complex Partial ☐ Generalized Tonic-Clonic (Grand Mal / Convulsive)

☐ Other (explain):

Date of last seizure: Length of seizure:

Name:_____ **DOB:**_____

OTHER HEALTH CONDITIONS:

☐ Anemia ☐ ADD ☐ ADHD ☐ CMV ☐ Mood disorder ☐ Cerebral Palsy ☐Chicken Pox ☐Cystic Fibrosis
☐Depression ☐ Digestive disorders ☐ Emotional / Psychological ☐ Hemophilia ☐ Skin Disorders ☐Sickle Cell Disease
☐Hemophilia ☐ Heart condition ☐ VP Shunt ☐ Feeding tube ☐Speech Problems ☐Physical Disability
☐ Juvenile Rheumatoid Arthritis ☐ Usher's Syndrome ☐Other (explain)_____

MEDICATION(S): ☐Yes ☐No List medication(s) name, strength, and directions:_____
_____

Special Procedures required (must have doctor's order) (i.e., catherization, oxygen, gastrostomy care, tracheostomy care/suctioning): ☐Yes ☐No
(explain):_____

Special Diet Required (must have doctor's order) (i.e., blended, soft, low salt, low fat, liquid supplement):
☐Yes ☐No
(explain): _____

Are there anticipated frequent absences or hospitalizations? ☐Yes ☐No (explain):_____

VISION CONDITIONS – Complete entire portion (circle)	**HEARING CONDITIONS – Complete entire portion** (circle)
Cause of visual impairment:	Cause of hearing impairment:
Diagnosed by age:	Diagnosed by age:
Age of onset:	Age of onset:
Private eye doctor: ☐Yes ☐No	☐Hearing aids (right/ left/ both) Aided by age:
If yes, name and location of doctor:	☐Cochlear implant (right/ left/ both)
☐Contacts / glasses (wears sometimes / always / lost / broken)	Cochlear Implant date: Last mapped:
☐Prosthetic eye (right / left / both) ☐ Other (explain):	☐Other (explain):

Physical Education/Sports Restriction(s): ☐Yes ☐No
(explain):_____

Special modifications to classroom or school schedule:
(i.e., temperature control, periodic breaks for endurance, part-time schedule)
☐Yes ☐No
(explain): _____

Special safety considerations:
(i.e., special precautions in lifting/positioning, special transportation, emergency plan, special safety equipment, special techniques)
☐Yes ☐No
(explain): _____

Special assistance with activities of daily living:
(i.e., toileting, eating, walking)
☐Yes ☐No
(explain): _____

_____ _____
Parent / Legal guardian signature Date

Entered into JCAMPUS on ___/____/____ by_____