FINAL 11/06

STATE OF LOUISIANA

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 an Individual Health Care Plan if needed. 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: M F		State or Country of Birth:	
Student's Mailing Address:	City:		State:	Zip Code:
Student's Physical Address:	City:		State:	Zip Code:

Name of Mother or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:
Name of Father or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:

Name of child's pediatrician or primary care provider:	Names of medical specialists or special clinics caring for your child:

_____

Parent or Legal Guardian Signature Date

Please check the type of health insurance your child has: Private Medicaid/LaCHIP None

If your child does not have health insurance, would you like information on no cost health insurance? Yes No

In case of emergency—if parent or legal guardian cannot be reached—contact the following:

Name Complete Phone Number ( )

My child has a medical, mental, or behavioral condition that may affect his/her school day: No Yes (If yes, please complete Part 2.)

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**

Allergy Type:

Food (list food(s)) _____

Insect sting (list insect(s)) _____

Medication (list medication(s)) _____

Other (list) _____

Reactions: (Date of last occurrence if yes.)

Coughing (Date:) Hives (Date:) Rash (Date:)

Difficulty breathing (Date:) Local swelling (Date:) Wheezing (Date:)

Generalized swelling (Date:) Nausea (Date:) Other _____ (Date:)

Currently prescribed medications and treatments:

Oral antihistamine(Benadryl, etc.) Epi-pen Other _____

❑ **ASTHMA**

Triggers: Environmental (i.e., tobacco, dust, pets, pollen, etc.) (list) _____ Other (list) _____

Does your child experience asthma symptoms with exercise? No Yes

Symptoms:

Chest tightness, discomfort, or pain Difficulty breathing Coughing Wheezing Other _____

Currently prescribed medications and treatments: _____

_____

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

Name: _____ DOB: _____

❑ **DIABETES**

Currently prescribed medications and treatments:

Insulin: Syringe Pen Pump
Blood sugar testing
Glucagon
Oral medication(s) List medication(s) _____
Is special scheduling of lunch or Physical Education required? No Yes

❑ **SEIZURE DISORDER**

Type of seizure:
Absence (staring, unresponsive) Complex Partial Generalized Tonic-Clonic (Grand Mal/Convulsive)
Other (explain) _____
Physical Education Restrictions: No Yes
Medication(s): No Yes List medication(s) _____

Date of last seizure _____ Length of seizure _____

❑ **OTHER HEALTH CONDITIONS**

Anemia ADD/ADHD Cancer Cerebral Palsy Chicken Pox Cystic Fibrosis
Depression Digestive disorders Emotional/Psychological Juvenile Rheumatoid Arthritis
Hemophilia Heart condition Physical disability Sickle Cell Disease Skin disorders
Speech problems Other (explain)_____
Physical Education Restrictions: No Yes (explain): _____

Medication(s): No Yes List medication(s) _____

Special procedures required (i.e., catheterization, oxygen, gastrostomy care, tracheostomy care, suctioning): No Yes (explain):_____

Special diet required (i.e., blended, soft, low salt, low fat, liquid supplement): No Yes (explain): _____

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

❑ **VISION CONDITIONS**

Contacts/glasses
Other _____

❑ **HEARING CONDITIONS**

Hearing aid(s)
Other _____

❑ **ENVIRONMENTAL ADJUSTMENTS DUE TO A HEALTH CONDITION**

Special school environmental adjustments of the school environment or schedule: No Yes (explain):_____

(i.e., seizures, limitations in physical activity, periodic breaks for endurance, part-time schedule, building modifications for access)

Special school environmental adjustments to classroom or school facilities: No Yes (explain):_____

(i.e., temperature control, refrigeration/medication storage, availability of running water)

Special safety considerations: No Yes (explain):_____

(i.e., special precautions in lifting, positioning, special transportation emergency plan, special safety equipment, special techniques for positioning, feeding)

Special assistance with activities of daily living: No Yes (explain):_____

(i.e., eating, toileting, walking)

PART 3: SCHOOL NURSE TO COMPLETE if parent/legal guardian indicates medical condition.

_____ _____
School Nurse Signature Date

Notes:

RETURN COMPLETED FORM TO SCHOOL NURSE/HEALTH OFFICE AS SOON AS POSSIBLE