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: La	ast	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: 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 Other (list)						
Reactions: (Date of last occurrent Coughing (Date: Difficulty breathing (Date: Generalized swelling (Date: Currently prescribed medication Oral antihistamine(Benade	te:) ons and treatments:	Hives (<u>Date:</u> Local swelling (<u>Date</u> : Nausea (<u>Date:</u>		□ Rash (<u>Date:</u>) □ Wheezing (<u>Date:</u>) □ Other (<u>Date:</u>)		
□ ASTHMA						
Triggers: Does your child experience asthmatic Symptoms: Chest tightness, discomfor Currently prescribed medications.	na symptoms with ex rt, or pain □ Difficul	lty breathing □ Coug		☐ Other (list)		
Date of last hospitalization related to asthma Date of last emergency room visit related to asthma						

FINAL 11/06	Name:	DOB:			
□ DIABETES					
Currently prescribed medications and treatments: Insulin:	□ Pump				
□ SEIZURE DISORDER	110 1100				
Type of seizure: Absence (staring, unresponsive) Other (explain) Physical Education Restrictions: No Yes Medication(s): No Yes List medication(s)	<u></u>				
Date of last seizure Lengt	h 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):					
Are there anticipated frequent absences or hospitalizations? No Yes (explain):					
□ VISION CONDITIONS	☐ HEARING CONDITIONS				
□ Contacts/glasses □ Other	☐ Hearing aid(s)☐ Other				
□ ENVIRONMENTAL ADJUSTMENTS DUE TO A HEALTH C	ONDITION				
Special school environmental adjustments of the school environment or schedule: No Yes (explain):					
(i.e., seizures, limitations in physical activity, periodic breaks for access) Special school environmental adjustments to classroom or		ications for xplain):			
(i.e., eating, toileting, walking)):tion emergency plan, special safety equipmen				
PART 3: SCHOOL NURSE TO COMPLETE if parent	legal guardian indicates medical condition				

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

School Nurse Signature

Notes:

Date