

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: <input type="checkbox"/> M <input type="checkbox"/> 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: <input type="checkbox"/> Private <input type="checkbox"/> Medicaid/LaCHIP <input type="checkbox"/> None				
If your child does not have health insurance, would you like information on no cost health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> No <input type="checkbox"/> 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.				
<input type="checkbox"/> ALLERGIES				
Allergy Type:				
<input type="checkbox"/> Food (list food(s)) _____				
<input type="checkbox"/> Insect sting (list insect(s)) _____				
<input type="checkbox"/> Medication (list medication(s)) _____				
<input type="checkbox"/> Other (list) _____				
Reactions: (Date of last occurrence if yes.)				
<input type="checkbox"/> Coughing (Date: _____)		<input type="checkbox"/> Hives (Date: _____)	<input type="checkbox"/> Rash (Date: _____)	
<input type="checkbox"/> Difficulty breathing (Date: _____)		<input type="checkbox"/> Local swelling (Date: _____)	<input type="checkbox"/> Wheezing (Date: _____)	
<input type="checkbox"/> Generalized swelling (Date: _____)		<input type="checkbox"/> Nausea (Date: _____)	<input type="checkbox"/> Other _____ (Date: _____)	
Currently prescribed medications and treatments:				
<input type="checkbox"/> Oral antihistamine (Benadryl, etc.)		<input type="checkbox"/> Epi-pen	<input type="checkbox"/> Other _____	
<input type="checkbox"/> ASTHMA				
Triggers: <input type="checkbox"/> Environmental (i.e., tobacco, dust, pets, pollen, etc.) (list) _____ <input type="checkbox"/> Other (list) _____				
Does your child experience asthma symptoms with exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Symptoms:				
<input type="checkbox"/> Chest tightness, discomfort, or pain <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Coughing <input type="checkbox"/> Wheezing <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Is peak flow monitoring used? <input type="checkbox"/> No <input type="checkbox"/> Yes				

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: