

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: please complete Part 2.)	No Yes (If yes,

**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: \_\_\_\_\_)
- Difficulty breathing (Date: \_\_\_\_\_)
- Generalized swelling (Date: \_\_\_\_\_)
- Hives (Date: \_\_\_\_\_)
- Local swelling (Date: \_\_\_\_\_)
- Nausea (Date: \_\_\_\_\_)
- Rash (Date: \_\_\_\_\_)
- Wheezing (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

**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**