STATE of LOUISIANA

HEALTH INFORMATION

TO BE COMPLETED BY PARENT / LEGAL GUARDIAN EACH SCHOOL YEAR

PART 1. **Parent or legal guardian to complete** and are encouraged to participate in the development of an Individualized Health Care Plan, if needed. Use additional sheets, if necessary, for further explanation.

School:		Grade:	
Student's Name:			
Date of Birth:	Sex: Male Female	State or Country of Birth:	
Mailing address:	City:	State:	Zip:
Physical address:	City:	State:	Zip:
Name of Mother / Legal Guardian:	Cell Phone: _____ Home: _____ Work: _____		Employer:
Name of Father / Legal Guardian:	Cell Phone: _____ Home: _____ Work: _____		Employer:
Name of student's pediatrician or primary care physician: _____ MD's Phone Number: _____	Names of student's medical specialists or special clinics:		

In case of Emergency: if parent or legal guardian cannot be reached – contact the following:

Name: _____ Phone: ( )_____

Please circle 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

My child has a medical, mental, or behavioral condition that may affect his/her school day:

YES ☐ Sign and Continue to PART 2. **NO ☐ Sign, then** STOP

_____ _____

Signature of Parent / Legal Guardian **Date**

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: Food:** _____ **Medication:** _____

☐ **N/A** **Insects:** _____ **Seasonal:** _____

Reactions: (Circle those that apply) Hives Rash Coughing Wheezing Nausea Generalized Swelling Local Swelling

Currently prescribed medications/treatments: Benadryl EPI Pen Other: _____

Date of last hospitalization and/ or emergency room visit related to allergic reaction: _____

☐ **ASTHMA: Triggers: Environmental** (tobacco, dust, pets, pollen) **Exercise** **Seasonal**

☐ **N/A** **Symptoms:** Chest tightness, discomfort, or pain Coughing Wheezing Shortness of breath

Other: _____

Currently prescribed medications and treatments: _____

Date of last hospitalization and/ or emergency room visit related to asthma: _____

Does your child have a written asthma management plan? Yes No Is peak flow monitoring used? Yes No

Name: _____ Date of Birth: _____

☐ **DIABETES: Currently prescribed medications and treatments:**
☐ **N/A** ☐ Insulin: Syringe Pen Pump List Medication: _____
☐ Blood sugar testing
☐ Glucagon
☐ Oral Medication(s): List Medication(s) _____

Is special scheduling of lunch or physical education required? Yes No

☐ **SEIZURE DISORDER: Type of Seizure:** ☐ Absence (staring, unresponsive) ☐ Complex partial
☐ **N/A** ☐ Generalized Tonic-Clonic (grand mal/convulsive) ☐ Other _____
Physical Education restrictions: Yes No
Date of Last seizure: _____ **Length of time for last seizure:** _____

Currently prescribed medication(s): Yes No **List Medication(s):** _____

☐ **OTHER HEALTH CONDITIONS:** ☐ Chicken pox: Date of disease: _____
☐ **N/A**

☐ Anemia ☐ Depression ☐ Physical disability: _____
☐ ADD/ADHD ☐ Emotional/Psychological ☐ Sickle Cell Disease/Trait
☐ Arthritis ☐ Juvenile Rheumatoid Arthritis ☐ Skin Disorder: _____
☐ Cancer ☐ Hemophilia ☐ Speech
☐ Cerebral Palsy ☐ Heart condition ☐ Other: _____
☐ Cystic Fibrosis ☐ Intestinal disorders

Currently prescribed medication(s): Yes No **List Medication(s):** _____

☐ Vision Conditions _____ ☐ Contacts ☐ Glasses ☐ Other
☐ Hearing Conditions _____ ☐ Hearing aid(s) ☐ Other

PLEASE NOTE: A DOCTOR'S ORDER IS REQUIRED FOR ALL SPECIAL ACCOMMODATION(S).

☐ **Physical Education restrictions:** Yes No If yes, explain: _____

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

☐ ENVIRONMENTAL ADJUSTMENTS DUE TO A HEALTH CONDITION

Special adjustments of the school environment or schedule needed? (i.e., seizures, limitations in physical activity, periodic breaks for endurance, part-time schedule, building modifications for access) Yes No
If yes, explain: _____

Special adjustments to classroom or school facilities needed? (i.e., temperature control, refrigeration/medication storage, availability of running water) Yes No
If yes, explain: _____

Special safety considerations required: (i.e., precautions in lifting or positioning, transportation, emergency plan, safety equipment, techniques for positioning or feeding) Yes No
If yes, explain: _____

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

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

Are there anticipated frequent absences or hospitalizations? Yes No
If yes, explain: _____

PART 3: SCHOOL NURSE TO REVIEW, if parent/legal guardian indicates medical condition _____
_____.

IHP Required: ☐ Yes ☐ No **School Nurse Signature** _____ RN, CSN **Date:** _____