LEWIS-PALMER SCHOOL DISTRICT 38

Health Information Form

School Year _____

TO: All Parents **FROM: School Nurse**

This information will help us provide the best services for your child. Thanks for your cooperation.

Student's Name_____**Birthdate**_____**Grade**_____
Parent(s)' Names_____ **Home Phone** _____
Work Phone_____ **Cell Phone**_____
Physician's Name, Address and Phone (indicate if none)_____
_____
Dentist's Name, Address and Phone (indicate if none) _____
_____
Preferred Hospital _____ Teacher/Team _____

CURRENT HEALTH CONCERNS

Check the conditions listed below if student ~~currently~~ has any of the following:

❑ ADD	❑ Autism	❑ Developmental Delays	❑ Orthopedic Problems
❑ ADHD	❑ Congenital Defects	❑ Head Injuries	❑ Prematurity
❑ Allergies	❑ Depression	❑ Heart Condition	❑ Seizures/Epilepsy
❑ ** has an EpiPen	❑ Diabetes – Type 1	❑ High Blood Pressure	Type of seizures:_____
❑ Asthma	❑ **pen/injections	❑ Migraines	_____
❑ ** has an Inhaler	❑ **pump	❑ Mood Disorder	❑ Other
❑ Asperger's	❑ Diabetes – Type 2	❑ Neurological Disorder	

If you checked any of the above please explain:_____
_____
_____
Is your child under medical care for any of these problems? Yes___ No___ If so, please explain:_____
_____

- **Does student take any medication regularly? Yes___ No___ Medication**_____
  Dosage_____**Times**_____**Taken for**_____
- **Has student had any immunizations in the last year? Yes___No___(Attach copy of record from health care provider)**
- **Has student had any serious injuries, illnesses or surgeries? Yes___ No___**
  Describe_____
- **Are there any physical conditions limiting the student's activities in school? Yes___ No___**
  Describe_____
- **Does student use any prosthetic devices (hearing aides, crutches, artificial limbs, or braces) in school? Yes___ No___**
  Describe_____
- **Does student wear: contact lenses _____ glasses _____? Have a known color deficiency? Yes___ No___**
- **Date of last vision exam** _____**Eye Physician**_____
- **Does student have any hearing, speech or language difficulties? Yes___ No___**
  Describe_____
- **Last physical exam**_____ **Last dental exam**_____
- **Does student have any special dietary limitations? Yes___ No___**
  If so, what: _____
- **Previously reported condition, which is now no longer a problem? Please explain**_____
  _____
- **Is there anything about your child that you would like to bring to our attention of a health, emotional or legal concern? Yes___ No___ (If yes, please use the back of this form to explain.)**
- **Does your child have an IEP, 504, or School Health Action Plan? Yes___ No___ (Please circle which document)**
- **Is your child covered by a health insurance plan or Medicaid?**
  If so, what is the name of the carrier? _____

I give permission for this information to be shared with adults in the school setting who will be working with my child on a need to know basis. It is the responsibility of the parent to notify the school nurse whenever there is any change in the student health status or care.

Parent Signature_____**Date**_____