STATE OF LOUISIANA
HEALTH INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

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.

Student Name Last / First / M I		Sex M ❑ F ❑	DOB	Grade	School
Student's Mailing Address		City		State	Zip
Student's Physical Address		City		State	Zip
Name of Mother/Legal Guardian	Home Phone	Work Phone		Cell Phone	Employer
Name of Father/Legal Guardian	Home Phone	Work Phone		Cell Phone	Employer
Name of pediatrician/primary care provider	Phone No	Name of medical specialists/clinics		Phone No.	

Parents: Please notify the school nurse of any changes in the student's medical condition.

Parent/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:

____

Name Phone Number Cell 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 **Parents are responsible to keep the school nurse informed regarding their child's health status.**

❑ALLERGIES

Allergy Type

❑Food (list food(s) ____________________

❑Insect sting (list insect(s) ______________

❑Medication (list medication(s) ____________

❑Other (list) ____________________

Reactions- Date of last occurrence

❑Coughing Date ____________ ❑Swelling Date ____________ ❑Rash Date ____________

❑Difficulty breathing Date _____ ❑Nausea Date ____________ ❑Other ____________

❑Hives Date ____________ ❑Wheezing Date ____________ ____________

Currently prescribed medications and treatments:
❑Oral antihistamine (Benadryl, etc) ❑Epi-pen ❑Other ______________________________

❑ASTHMA
Triggers (i e , tobacco, dust, pets, pollen, etc) (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 ER 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) ❑Generalized Tonic-Clonic (Grand Mal/Convulsive)
❑Complex Partial ❑Other (explain) ______________________________
Physical Education Restrictions ❑No ❑Yes
Medication(s): ❑No ❑Yes List medication(s) ______________________________
Date of last seizure ______________ Length of seizure ______________________

❑ OTHER HEALTH CONDITIONS **Chicken Pox: Date of disease:** ______________

❑Anemia	❑Digestive disorders	❑Sickle Cell Disease
❑ADD/ADHD	❑Psychological	❑Skin disorders
❑Cancer	❑Juvenile Rheumatoid Arthritis	❑Speech problems
❑Cerebral Palsy	❑Hemophilia	❑Other (explain)____________
❑Cystic Fibrosis	❑Heart condition	
❑Depression	❑Physical disability	

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). ____

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❑ **VISION CONDITIONS**______ ier____________________

❑ **HEARING CONDITIONS**________________ ❑Hearing aid(s) ❑Other ____________________

❑ **ENVIRONMENTAL ADJUSTMENTS DUE TO A HEALTH CONDITION**

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

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

____

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

____

Special assistance with activities of daily living needed: ❑No ❑Yes (explain)
(*i e , eating, toileting, walking)*

____

Special diet required? ❑No ❑Yes (explain)
(i e , blended, soft, low salt, low fat, liquid supplement) ____________________

Are there anticipated frequent absences or hospitalizations? ❑No ❑Yes (explain)

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

Nurse Notes ____

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____

____

School Nurse Signature

Date

Emergency Plan

Student: ____ Date: ___________

Parent/Guardian:____

Address:____

____

Home Phone: ___________________________Work:________________________________

Emergency Room Phone Number:____

Physician's Name: ____

Alternate Contact: ____

Home Phone: ____________________________ Work: ____________________________

I am aware that if my child has an emergency in school and I am not available, the school principal or alternate will have my child transported to the emergency room. I will be responsible for payment of emergency care.

__________________________ ______ ________________________________

Signature Parent/Guardian Date Witness

PLEASE DOCUMENT PROBLEMS AND RESPONSES ON BACK

STUDENT SPECIFIC EMERGENCIES

IF YOU SEE THIS	DO THIS

IF AN EMERGENCY OCCURS:

If the emergency is life-threatening, immediately call 9-1-1

Stay with the student or designate another adult to do so.

Call or designate someone to call the principal and/or health care coordinator.

State who you are:

State where you are:

State problem:

If the school liaison is unavailable, the following staff members are trained to deal with an emergency and to initiate the appropriate procedures.