Lake Elsinore USD
School Year 2015-16

Health Form

Student ID: _____
First Initial: _____ Last Name: _____

STUDENT INFORMATION

Last Name	First Name	Middle Name	Date of Birth	Gender	Grade

MEDICAL INFORMATION

PLEASE UPDATE HEALTH INFORMATION ANNUALLY (Parents/Guardians, Please circle and update any changes to medical information)

DOES YOUR CHILD HAVE ANY HEALTH CONCERNS? ☐ **NO** ☐ **YES** **Please mark box(es) below.**

ALLERGIES:

MILD/MODERATE

- ☐ Bees/Insects (mild, local reaction)
- ☐ Food Intolerance (list)_____
- ☐ Medication (list)_____
- ☐ Environmental (list)_____

SEVERE/LIFE THREATENING

Epipen required at school - Form #7109*

- ☐ Bees/Insects
- ☐ Foods

(Food Accommodation Form #7805)*

- ☐ Other

SCOLIOSIS

- ☐ Wears back brace
- ☐ Had scoliosis surgery - Date:_____

ASTHMA

- ☐ History of Asthma
- ☐ Medication used at home
- ☐ Medication needed at school* Form#7127*
- ☐ Nebulizer treatment*

OTHER CONDITIONS:

- ☐ ADHD - no medication
- ☐ ADHD - medication / list below
- ☐ Autism
- ☐ Arthritis
- ☐ Blind
- ☐ NO Blood or Blood Products
- ☐ Cancer - Year/Type: _____
- ☐ Cerebral Palsy
- ☐ Cystic Fibrosis
- ☐ Diabetes, Form #7171*
- ☐ Eating Disorder - CONFIDENTIAL
- ☐ Epilepsy/Seizures - Type:_____
- ☐ Hearing Loss:_____
- ☐ Hearing Aid Used
- ☐ Heart Condition - Type:_____
- ☐ Hemophilia
- ☐ Kidney Disorder - Type:_____
- ☐ Mental Health/Behavior - CONFIDENTIAL (list)_____
- ☐ Mobility Limitations: _____
- ☐ Muscular Dystrophy
- ☐ Non-Verbal
- ☐ Organ Transplant
- ☐ Sickle Cell Anemia
- ☐ Tuberculosis - Treatment Year:_____
- ☐ Visually Impaired
- ☐ Wears Glasses/Contacts
- ☐ Other Explain below

MEDICATION/PLEASE LIST BELOW

- ☐ Given at home:
  - Name of Medication:_____
  - Dosage:_____
- ☐ Given daily at school* Form#7804*
- ☐ Given as needed at school* Form#7804*

***All medications** (prescribed and over-the-counter) given during the school day **MUST have a current Form#7804** Authorization for Medication Administration (or equivalent) completed and signed by the physician and parent. It is recommended that a 3 day supply of medication for chronic conditions be supplied to the school by the parent/guardian in case of disaster.*

SPECIAL PROCEDURES NEEDED AT SCHOOL (may require a doctor's order)

☐ Catheterization ☐ Tracheostomy/Suctioning ☐ Diapering/Toileting assistance ☐ Gastrostomy Tube/Ostomy ☐ OTHER _____

Comments:

Name of Physician: **Phone:**

Address: **Type of Insurance:** **Policy Number:**

***Dear Parent/Guardian:** Your signature below authorizes the school district to obtain medical care or necessary emergency treatment for serious injury, accident, or illness (at your expense) with your physician, or emergency room physician of the school's choice. In the event emergency treatment is necessary, the school district will be held harmless in all decisions.*

Please contact the school if medical information changes throughout the school year

Parent/Guardian Name (print):_____

Parent/Guardian Signature (*required*):_____ **Date:**_____