Lakeland School System
Confidential Student Health Information Form

Student:	**Grade:**	**School Year 20_____ - 20_____**
School:	**DOB: _____/_____/_____**	**Male or Female (circle one)**

General Information

The request for identifiable health information will enable us to provide safe and appropriate health care if your child becomes ill or injured at school or on the bus. The information that you provide will be maintained confidentially and is limited to individuals that work with your child within the school setting with a legitimate need to know. If you have any questions or would like to discuss specific health issues, please call the school directly during school hours or call the Department of Coordinated School Health.

Parent/Guardian Information

Last Name	First Name	Relationship	Phone

Physician Contacts

Physician Name	Phone	Address

Please review the following list and check any and all that apply

	ADHD		Type I Diabetes		Meningitis		**Procedure Below**:
	Anemia		Type II Diabetes		Migraine Headache		Catheterization
	Anxiety attack		Depression		Nosebleeds		Tube Feeding
	Arthritis		Dialysis		Panic attacks		**Equipment Below**:
	Artificial joints		Fractures (Skull)		Rheumatic Fever		Crutches
	Artificial valves		Heart Problems		Scoliosis		Walker
	Asthma Is rescue inhaler needed? ____Y_____N		Hemophilia		Seizures		Wheelchair
	Autism/Asperger's		High Blood Pressure		Sickle Cell Anemia		**Other equipment/procedures:**
	Cancer		Kidney Problems		Stroke		
	Concussion Date:		Leukemia				
	Cystic Fibrosis		Low blood pressure		Other		

Other, including health equipment/procedures please provide specific information:

ALLERGY INFORMATION: IS YOUR CHILD ALLERGIC TO ANY OF THE FOLLOWING? (Check any that apply and list the specifics)

	Medication (list specifics) -	
	Food (tree nuts-peanuts-fish-milk/dairy – list specifics) -	EpiPen required? _____yes _____no
	Insects (bees-wasps-ants – list specifics) -	EpiPen required? _____yes _____no
	Latex	
	Other (list specifics) -	

Name additional medications (if any) your child takes to treat an allergic reaction:

_____

Does your child routinely take medication at home? If yes, please list:

Name of Medication	Dose	Time Taken

*As the parent/guardian, **I do** _____ **I do not** _____ give permission to release health information to appropriate school system staff.

Parent Signature:_____ **Date: _____/_____/_____**

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Revised 01/2015