CONFIDENTIAL STUDENT HEALTH INFORMATION FORM
2017-18
Lakeland School System

Please Print Below

Student Name_____ 2017-18 Grade _____

Gender: M ☐ F ☐ Date of Birth _____ *(mm-dd-yyyy)*

School _____ Homeroom Teacher _____

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 with Health Services staff, please call your school directly during school hours.

Release of Health information (Please initial only one below)

	Parent **gives** permission to release health information to appropriate school system staff for medical alert notification and health care management.
	Parent **prohibits** disclosure of sensitive health information to school staff unless medically necessary without specific request and school nurse involvement.

Parent/Guardian Information

Last Name	First Name	Relationship	Phone

Emergency Contacts

Last Name	First Name	Relationship	Phone

Physician Contacts

Physician Name or Office	Clinic/Practice Name and Address	Phone

Please Review The Following List and Check Any And All That Apply.

	ADHD		Cystic Fibrosis		Migraine Headache		
	Anemia		Diabetes		Nosebleeds		
	Anxiety attack		Depression		Panic attacks		
	Arthritis		Dialysis		Reflux		
	Artificial joints		Glasses		Scoliosis		
	Artificial valves		Headaches		Seizures		
	Asthma		Hearing Problems		Sickle Cell anemia		
	Back Problems		Heart Problems		Sinus Problems		
	Broken bones		Hemophilia		Stroke		
	Cancer		High Blood Pressure		Vision Problems		
	Contact lenses		Kidney Problems		Vomiting		
	Concussion		Leukemia				

Other, including health procedures:
If any are checked, please provide specific information:

PLEASE COMPLETE REVERSE SIDE

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Revised 02/2017

ALLERGY INFORMATION: IS YOUR CHILD ALLERGIC TO ANY OF THE FOLLOWING?

Medication (Name)	Environmental (Trees, Grass)	Does your child require an epinephrine for an allergic reaction?	Name of medications your child takes in addition to the Epinephrine to treat an allergic reaction:
Food (Tree nuts, Peanuts, Fish, Milk, Egg)	Dyes (Red, Yellow)	YES ☐ NO ☐	
Insects (Bees, Wasps)	Other	If yes, what type and dose level:	
Latex			

MEDICATION INFORMATION: DOES YOUR CHILD ROUTINELY TAKE MEDICINE AT HOME OR SCHOOL? YES ☐ NO ☐
IF YES, PLEASE PROVIDE INFORMATION BELOW:

DIAGNOSIS FOR WHICH MEDICINE IS GIVEN	NAME OF MEDICATION	FORM (PILL, LIQUID, INHALER)	DOSAGE	SPECIFIC TIME(S) TO BE GIVEN	GIVEN AT HOME	GIVEN AT SCHOOL

PARENT/GUARDIAN ACKNOWLEDGEMENT: I acknowledge that my child may be allowed to take his/her medication according to Board policy. I also understand that I must personally bring all medications that are deemed medically necessary for administration during the school day to the office and complete a Parent Authorization Form for Administration of Medication. This document will be placed in the school office.

I understand that although a reasonable attempt will be made to remind the student about medications, it is expected that the student will be responsible for obtaining his/her medication if required for self-administration during the school day.

I agree to indemnify and hold harmless LSS and its employees from claims relating to the possession or self-administration of asthma inhalers, and understand that LSS, its employees and agents shall incur no liability as a result of injury to a student or any other person as a result of possession or self-administration of asthma inhalers.

I also authorize the school nurse and district health services staff to consult with the prescribing physician to clarify medication orders, or, in the interest of the student's health, to discuss his/her response to the prescribed medication. All health information will be kept confidential.

_____ _____ _____
Date Parent/Guardian Signature Telephone

FOR SCHOOL STAFF ONLY

Note: The School Nurse will review this form to determine the level of disclosure and appropriate action:

Medical Alert ☐ IHP to be developed ☐

Other_____

School Nurse review date and signature: _____

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