# Health Information

**State of Louisiana**

**Health Information**

To be completed by Parent/Legal Guardian each school year.

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name's Name</td>
<td>First</td>
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<tr>
<td>Last</td>
<td>M.I.</td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
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<tr>
<td>Sex: M</td>
<td>F</td>
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<tr>
<td>State or Country of Birth</td>
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<tr>
<td>Mailing Address:</td>
<td>City</td>
</tr>
<tr>
<td>State:</td>
<td>Zip Code:</td>
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<tr>
<td>Physical Address:</td>
<td>City</td>
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<tr>
<td>State:</td>
<td>Zip Code:</td>
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<tr>
<td>Home Phone:</td>
<td>Work Phone:</td>
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<tr>
<td>Cell Phone:</td>
<td>Employer:</td>
</tr>
<tr>
<td>Parent or Legal Guardian</td>
<td>Complete Phone Number</td>
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<tr>
<td>Guardian:</td>
<td></td>
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<tr>
<td>Name of Mother or Legal Guardian</td>
<td></td>
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<tr>
<td>Name of Father or Legal Guardian</td>
<td></td>
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<tr>
<td>Name of Child's pediatrician or primary care provider</td>
<td></td>
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<tr>
<td>Names of medical specialists or special clinics caring for your child:</td>
<td></td>
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</tbody>
</table>

**Parent or Legal Guardian Signature**

Date

Please check the type of health insurance your child has:  □ Private  □ Medicaid/LaCHIP  □ None

Do you have health insurance, would you like to know about no-cost health insurance? □ Yes □ No

In case of emergency—If parent or legal guardian cannot be reached—contact the following:

Complete Phone Number

Is your 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.

## ALLERGIES

- **Allergy Type:**
  - Food (list food(s))
  - Insect sting (list insect(s))
  - Medication (list medication(s))
  - Other (list)

- **Reactions:**
  - Coughing (Date: )
  - Difficulty breathing (Date: )
  - Local swelling (Date: )
  - Nasal congestion (Date: )
  - Other (Date: )

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

## ASTHMA

- **Triggers:**
  - Environmental (i.e., tobacco, dust, pets, pollen, etc.)
  - Other (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 emergency room visit related to asthma

  Does your child have a written asthma management plan? □ No □ Yes

  Is peak flow monitoring used? □ No □ Yes

Continued on back
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)
- Complex Partial
- Generalized Tonic-Clonic (Grand Mal/Convulsive)
- Other (explain)

Physical Education Restrictions: □ No □ Yes
Medication(s): □ No □ Yes List medication(s)

Date of last seizure
Length of seizure

OTHER HEALTH CONDITIONS
- Anemia
- ADD/ADHD
- Cancer
- Cerebral Palsy
- Chicken Pox
- Cystic Fibrosis
- Depression
- Digestive disorders
- Emotional/Psychological
- Juvenile Rheumatoid Arthritis
- Hemophilia
- Heart condition
- Physical disability
- Sickle Cell Disease
- Skin disorders
- Speech problems
- Other (explain)

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):

Special diet required (i.e., blended, soft, low salt, low fat, liquid supplement): □ No □ Yes (explain):

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

VISION CONDITIONS
□ Contacts/glasses
□ Other

HEARING CONDITIONS:
□ Hearing aid(s)
□ Other

ENVIRONMENTAL ADJUSTMENTS DUE TO A HEALTH CONDITION
Special school environmental adjustments of the school environment or schedule: □ No □ Yes (explain):
(i.e., seizures, limitations in physical activity, periodic breaks for endurance, part-time schedule, building modifications for access)

Special school environmental adjustments to classroom or school facilities: □ No □ Yes (explain):
(i.e., temperature control, refrigeration/medication storage, availability of running water)

Special safety considerations: □ No □ Yes (explain):
(i.e., special precautions in lifting, positioning, special transportation emergency plan, special safety equipment, special techniques for positioning, feeding)

Special assistance with activities of daily living: □ No □ Yes (explain):
(i.e., eating, toileting, walking)

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

School Nurse Signature __________________________ Date ______________

RETURN COMPLETED FORM TO SCHOOL NURSE/HEALTH OFFICE AS SOON AS POSSIBLE