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) _____ ❑ Medication (list medication(s) _____

❑ Insect sting (list insect(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): _____
_____

❑ **VISION CONDITIONS**_____ ❑ Contacts/glasses ❑ Other_____
❑ **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)

_____

_____

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):

_____

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

Nurse Notes: _____

_____

_____

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_____ _____

School Nurse Signature Date