Health Centers in Schools
A Partner of Our Lady of the Lake Children's Health

Request for Health Information

Must be completed annually

Date:________________

Please return the following form to your child's teacher or ESS/PAS staff **as soon as possible.** This information will be provided to the School Nurse for review (a signed State of LA Release of Medical Information is required if a school health plan is warranted).

Student Name:	Homeroom Teacher/Grade:	Bus#:
School:	**Date of Birth:**	Home Phone:
Parent/Guardian:	Daytime Phone:	
Parent/Guardian:	Daytime Phone:	
Emergency Contact:	Phone:	
Current Doctor/Practice:	Phone:	
Medication allergies and reaction(s): ☐ NONE KNOWN ☐ Yes (list):		
Current Medications:		
Does your child need medications at school: ☐ No ☐ Yes* (list):		

(*) Medication order form is required to be signed by the student's health care provider and the Medication consent form is required to be signed by parent/guardian.
Medication cannot be given until BOTH forms have been received by school nurse.

CHECK THE CONDITION(S) YOUR CHILD HAS BELOW, OR ☐ MY CHILD HAS NO KNOWN HEALTH CONDITIONS
(You may stop here if there are no known medical conditions. Please sign at the bottom and return form).

__**ADD/ADHD** (See Below)	__Cerebral Palsy	__Hearing Aid/Loss	__Neuromuscular Disease
__Allergies, Seasonal	__Crohn's Disease/IBS	__**Head Injury/Concussion** **Date Diagnosed:** ____________	__Orthopedic Disability
__**Allergies, Severe** (See Below)	__Cystic Fibrosis	__Heart Conditions Type: ______________	__Renal/Kidney Disease
__**Asthma** (See Below)	__**Diabetes** (See Below)	__Hemophilia/Bleeding Disorder	__Juvenile Rheumatoid Arthritis
__Autism	__Down's Syndrome	__**Mental Health Diagnosis** (See Below)	__Sickle Cell Anemia
__Cancer/Leukemia Date Diagnosed:___________	__**Epilepsy/Seizures** (See Below)	Migraine Headaches	__Ulcers/Gastric Reflux
	__Glasses/Contacts		__Other:____________

FOR THE FOLLOWING CONDITIONS, PLEASE PROVIDE ADDITIONAL INFORMATION:

Severe Allergies Notify your School Nurse ***IMMEDIATELY*** If anaphylaxis may occur.	What is your child allergic to? ☐ Peanuts ☐ Tree Nuts ☐ Milk ☐ Eggs ☐ Insect Stings ☐Other: ______________ Is medication needed at school for allergies? ☐ No ☐ Yes* If yes, name: ______________ Location of Medication: ☐ Carried by student* **(requires provider release)** ☐ Classroom ☐ Health Room Date/Type Last Reaction:______________Check the type of allergic reaction that occurs: ☐ HIVES ☐ SWELLING ☐ DIFFICULTY BREATHING ☐ OTHER: ______________
Asthma	Is medication needed at school for asthma? ☐ No ☐ Yes* If yes, name: ______________ Location of Medication: ☐ Carried by student* **(requires self-carry form)** ☐ Classroom ☐ Health Room Date of last episode: ______________ Triggers: ☐ Environmental ☐ Seasonal ☐ Exercise induced ☐ Upper respiratory infection ☐ Other:__________
Epilepsy/ Seizures	Type: ☐ Febrile Only ☐ Convulsive ☐ Non-Convulsive Date of last seizure: ____________ Is emergency medication needed at school? ☐ No ☐ Yes* If yes, name: ______________
Diabetes	Type I ☐ Type II ☐ Diagnosis Date: ______________ * **Insulin** by: ☐ Pump ☐ Injections **CGM** (i.e.: Dexcom): ☐ No ☐ Yes, Type: __________ ***Please call to schedule School Nurse Conference - Notify your school nurse immediately if newly diagnosed***
ADD/ADHD Mental Health	Type: ☐ ADD/ADHD ☐ Anxiety ☐ Depression ☐ Other: ______________ Medication used for treatment: ______________

Please be aware that the information you provide will be shared with staff on a need-to-know basis.

In the event of an emergency, and I cannot be reached, I give permission for the School Nurse to contact my child's medical provider for further instructions on medication(s) and/or care.

______________________________ ______________

Signature of Parent/Guardian **Date**