Little Falls Community Schools Health Form

ISD 482

Dear Parent/Guardian:

Please complete form in its entirety, sign and return to your child's nurse's office.

****This is a required document****

Student Name: _____ Birth Date: ___/___/___ Grade: _____
Last First Middle Initial

Emergency Contact #1:_____
(parent/guardian information) Name Phone Number Alternate Phone Number

Emergency Contact #2:_____
(Other than parent/guardian) Name Phone Number Alternate Phone Number

Current Health Status **Please check the appropriate box(s) and describe concerns (use reverse side if necessary):**

_____ Allergies (List them) _____
_____ Asthma or other breathing problem _____
_____ Diabetes_____
_____ Heart Problems _____
_____ Seizures _____
_____ Social/emotional/mental health (Including ADD/ADHD)_____
_____ Bladder/Bowel concerns or modifications needed _____
_____ Activity Restrictions _____
_____ Other health concern or significant history of problems _____
_____ Vision or hearing concerns (glasses or hearing aids)_____
_____ Headaches _____
_____ Recent Immunizations _____
_____ Recent surgery, injury or hospitalization _____
_____ No Health Concerns

EMERGENCIES: Does this student have a health problem that could result in an emergency?
(ex. Life threatening allergy)
NO_____ YES_____ If yes, describe:_____

Note: 911 will be called in an emergency

MEDICATIONS: List **ALL** medications that this student takes daily or as needed, this includes over the counter medications. **(use reverse side if necessary)**

Please note: Please see your school nurse for appropriate forms if your child is needing medications during school hours.

Medication	***Dose***	***Purpose***	***Frequency***

_____ ____/____/____
Parent's Signature **Today's Date**