Lewistown Public Schools

Student Heath Information

Name____Birthdate________________Grade_____________

Life Threatening or Severe Medical Conditions

☐**Severe Allergy/Anaphylaxis with Epi Auto Injector Prescription** (aka Epi Pen)
Circle Type and List Allergen if Applicable:
Food or Nuts (List Allergen/s)_______________________________ **Bee Stings** **Other** (List Allergen/s)______________________

☐**Diabetes:** Date of Diagnosis:______________ Management: ☐**Insulin Pump** ☐**Insulin Pen** ☐**Injections** ☐**CGM**

☐**Seizure Disorder:** Date of Diagnosis___________ ☐Emergency Medication for Seizure

☐**Asthma (Moderate to Severe)**
Does your child use a rescue inhaler routinely for asthma symptoms? ☐Yes ☐No
Will your child require asthma medication during school hours? ☐Yes ☐No
Has your child been hospitalized for asthma in the past year? ☐Yes ☐No
Has your child used steroids (prednisone) for asthma symptoms in the past year? ☐Yes ☐No

☐**Asthma (Mild)**
☐My Child has a history of asthma, but does not routinely take asthma medication or use a rescue inhaler.
☐I will update the school and/or school nurse if changes in condition occur. Please Initial _______

☐**Other Potentially Life-Threatening Conditions** (ex: Cardiac- requiring AED etc.)____
☐**My Child has NONE of the conditions listed above**
Alert to Parents/Guardians: The school **must** know of any conditions that could lead to a significant health crisis or emergency **prior** to the start of the school year. An Emergency Care Plan and/or written orders/signature from the student's Health Care Provider and parental signature is needed for any of the above conditions. Please contact the school nurse for individual health care needs. Forms are available.

Allergies (not listed above that do not require an Epi Pen)

☐Medications ☐Food ☐Seasonal ☐Environmental ☐Other ☐No Known Allergies
Please state allergen/s and describe reaction and intervention:

Medications: Does your child take any daily medications? ☐Yes ☐ No (If Yes, Please indicate below)

Name of Medication	Dosage	Reason

Medications are required to be given at home whenever possible. **Does your child require medication to be given at school** ☐**Yes** (Contact School Nurse or Administrator)
Prescription Medications: Must have a physician's order and signature, parental signature, must be in original pharmacy container with label.
Non Prescription/Over the Counter Medications: Must be brought by parent/guardian in the original container with child's name on it. Parental signature required.
Self-Administration or Possession of Asthma/Severe Allergy Medication: Montana law requires written authorization.
(Forms are available for all of the above)

Other Health or Developmental Conditions/Concerns (Check if your child has/had any of the following concerns the school should be aware of)

☐ADD	☐Emotional	☐Vision	☐Hearing	☐Headaches	☐Kidney/Bladder	☐Lung	☐Illnesses
☐ADHD	☐Behavioral	☐Glasses	☐Hearing Aid	☐Concussion	☐Bone/Muscle	☐Heart	☐Surgeries
☐Autism	☐Mental Health	☐Contacts	☐Ear Infections	☐Food Intolerance	☐Stomach/Bowel	☐Bleeding	☐Hx of Seizures
☐Speech	☐Learning	☐Skin	☐Sinusitis	☐Congenital	☐Hospitalizations	☐Dental	☐Other

If Box/s Checked Please Explain:

☐Special Healthcare Needs (wheelchair, tube feedings, catheter, breathing tube, intravenous lines etc.) Contact School Nurse or Administrator.

______All immunizations required by the State of Montana are needed prior to the beginning of the school year. (Exemptions must be on file prior to the start of school.)

_____Topical, non-ingestible creams and ointments may be used sparingly for minor discomforts based on assessment and clinical judgement of the school nurse according to the label. These include anti-itch cream, hydrocortisone cream, antibiotic ointment, Sting relief (benzocaine), Muscle gel, Oral numbing gel. Petroleum Jelly, Sunburn relief.

_____This information is considered confidential. To ensure the health and safety of your child, it will be shared with school staff only as needed. The above information is accurate to the best of my knowledge, and I will notify the school if changes in my child's health status occur.

______Pursuant to Montana Law (20-5-421) LPS maintains a stock supply of Auto-Injectable Epinephrine (Epi Pens) to be used in the event of a previously undiagnosed life threatening allergic reaction. Properly trained personnel may administer the medication to any student or non-student experiencing a potentially life-threatening anaphylactic reaction. Follow up Emergency Care will ensue. *(Does not replace individual orders for students with known anaphylaxis)*

______In the event of any emergency or accident involving my child, I give permission to school personnel to take appropriate emergency action, including 911 for transportation to a hospital.

(Please Initial Above) Parent/Guardian Signature____Date___________________________