Luxemburg-Casco School District
Health History

Student's Name _____ School Year _____-_____

Date of Birth _____ Age _____ Grade Entering _____

Please fill out this health form as accurately as possible. The school nurse will share any pertinent health information with school staff on a need-to-know basis for academic success and emergency plans. If any of this information should change during the school year, please let the nurse know.

❑ Yes ❑No Allergies:

If yes, allergy to: Food: _____

Medications: _____

Bee Stings: _____

Other: _____

❑ Yes ❑No Epi-Pen: If yes, please complete ***FARE (Food Allergy & Anaphylaxis Emergency Care Plan)***

❑ Yes ❑No Asthma: _____

*If yes, please complete ***Authorization for Administration of Inhaled Medication*** form

❑ Yes ❑No Epilepsy/Seizures: *If yes, please complete ***Seizure Action Plan*** form

❑ Yes ❑No Vision problems: _____

Wears: ❑ Glasses ❑ Contacts

❑ Yes ❑No Hearing problems: _____

If yes, which ear? ❑ Right ❑ Left ❑ Both

Hearing Aides: ❑ Right ❑ Left ❑ Both

❑ Yes ❑No Diabetes Date of Diagnosis: _____

*If yes, please complete ***Diabetes Medical Management Plan*** or submit doctor provided *Diabetes Individual Health Plan (IHP)*

❑ Yes ❑No Medications taken at home: _____

❑ Yes ❑No Medications to be taken at school: _____

Please complete the ***Prescription Medication Consent*** form

Updated: 03/18/2019

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❑ Yes ❑No Chronic neurological problems: _____

❑ Yes ❑No Chronic abdominal/bowel problems: _____

❑ Yes ❑No Chronic heart problems: _____

❑ Yes ❑No Mental health concerns: _____

❑Yes ❑No Depression_____
❑Yes ❑No Anxiety_____
❑Yes ❑No Self-harm_____
❑Yes ❑No Behavioral Concerns_____
❑Yes ❑No Emotional Concerns_____

❑ Yes ❑No ADD/ADHD: _____

❑ Yes ❑No Autism: _____

❑ Yes ❑No Developmental delays: _____

❑ Yes ❑No Bone/joint/muscle problems: _____

❑ Yes ❑No Activity restrictions: _____

❑ Yes ❑No Any other medical concerns you would like the nurse to know about: _____

_____

Parent/Guardian Signature: _____Date: _____