School Year_____

STUDENT HEALTH FORM

Lakeview Public School District #2167
P O Box 107, 875 Barstad Road,
Cottonwood, MN 56229
Phone: (507) 423-5164 Ext. #1154 Fax: (507) 423-5568

STUDENT NAME _____ BIRTHDATE_____
LAST FIRST MI

☐MALE ☐FEMALE

PRIMARY Care Provider_____PHONE_____

Date of last wellness exam or physical:_____Preferred hospital for emergencies_____

Name of medical insurance (if none, write none)_____

Dentist:_____ Last dental exam:_____

Does the student wear eye glasses or contacts? ☐ Yes ☐ No Date of last eye exam_____

Does the student wear hearing devices? ☐ Yes ☐ No Date of last hearing exam_____

Current Health Problems:

Please put an (x) if the student has any of the following conditions:

☐ The Student has NO medical or mental health problems.

Or (Check all that apply)

☐ ALLERGIES- (include allergies to medications, foods, animals, insects, environment etc.) List allergy and reaction:

_____

_____

LIFE THREATENING?: ☐YES ☐NO

Has EPI PEN: ☐YES (☐ Self-carries, ☐ Keep in Health Office) or ☐NO Pen needed

Note: Epinephrine require a provider's order to be delivered to the Health Office annually.
Life threatening allergies also require an Emergency Action Plan form to be completed annually
A Special Diet Request Form is also required for food allergies, review or submit annually.

☐ ASTHMA- or other breathing problems: _____

Uses Inhaler or nebulizer ☐YES ☐NO

Medication will be stored in the Health Office? ☐YES ☐NO

(Asthma Action Plan or Emergency Action Plan forms need to be submitted annually)

Student will keep medication with them? ☐YES ☐NO

(Requires Self-Possession of Asthma Medication in School form)

☐DIABETES- Takes oral medications? ☐YES ☐NO Has Insulin Pump? ☐YES ☐NO

Note: Updated Provider's orders and Diabetic Emergency Action Plan is required annually
(All diabetic supplies, medications, and snacks must be provided by the family and stored in Health Office)

☐SEIZURE DISORDER TYPE (IE; epileptic, febrile) _____ Date of last seizure_____

Is Diazepam (Nasal Spray or Injection) or other emergency medication needed? ☐YES ☐NO

Medication will be stored in the Health Office? ☐YES ☐NO

Student will keep medication with them? ☐YES ☐NO

(Emergency Action Plan and provider's orders needs to be submitted annually)

☐PHYSICAL LIMITATIONS: _____

_____

☐STOMACH/BLADDER/BOWEL PROBLEMS:_____

_____

(The school does NOT provide pull-ups, wipes, clothing or other personal supplies. This is the family's responsibility. Supplies can be stored for the student in the Health Office or Special Needs bathrooms.)

☐ ADHD/ADD ☐ANXIETY ☐DEPRESSION ☐PANIC ATTACKS ☐SOCIAL PHOBIA

Requires medication during the school day? ☐YES ☐NO (Enter on Medication Administration Form)

☐ALL OTHER HEALTH/MENTAL HEALTH/SOCIAL/BEAHAVIORAL CONCERNS OR COMMENTS

(Please also list any significant past medical or surgical history we should be aware of.)

_____

_____

_____

_____

_____

_____

_____

MEDICATIONS TAKEN AT HOME (enter medications for school on attached Medication Administration Form)

Medication	How Much (dosage)	When given (how often)	What is it for?

Note: You may also send additional comments/forms/paperwork to HealthOffice@lakeview2167.com or drop off at the Elementary/High School Offices

☐ I understand that health information is protected however, certain limited information may be shared with school employees and emergency personnel as needed for the care of the student.

PARENT/GUARDIAN SIGNATURE_____DATE_____

Student Name_____ Date of Birth_____

MEDICATION ADMINISTRATION FORM
(FORM TO GIVE MEDICATIONS AT SCHOOL)

STUDENT NAME _____ BIRTHDATE_____

PRESCRIPTION MEDICATION TO BE GIVEN AT SCHOOL

☐ I request the following medications, that I will provide, to be given at school as prescribed by my student's provider. I understand that the medications need to be in the original containers and will be distributed per the instructions on the label. Exact timing of medication distribution will be coordinated with the Health Office and the student's teacher. I understand that a parent or legal guardian is required to retrieve the medication at the end of the school year or when requested by the school. I authorize the school district to transport and dispose of any medication that remains in the possession of the school after the requested retrieval date. For controlled substances, any medication that is not picked up will be released to the County Sheriff's Department for proper disposal.

Medication	How Much (dosage)	When given (how often)	What is it for?

OVER THE COUNTER MEDICATIONS AT SCHOOL

☐ I request the following over-the-counter medications, that I will provide for my student, to be kept and distributed to my student per instructions on the container. I understand that a parent or legal guardian is required to retrieve the medication at the end of the school year or when requested by the school and authorize the school district to transport and dispose of any medication that remains in the possession of the school after the requested retrieval date.

Medication	How Much (dosage)	When given (how often)	What is it for?

PARENT/GUARDIAN SIGNATURE_____DATE_____

***The 2nd page of this form must be filled out by all parents/guardians at least one time per year.

PARENT/GAURDIAN APPROVAL STATEMENTS
FOR OVER-THE-COUNTER MEDICATIONS IN THE HEALTH OFFICE

(Recommend to update annually with registration and as needed)

* The Health Office tries to stock some basic over-the-counter supplies to help your students as needed at school. I authorize the Health Office to administer the following over-the-counter medications if needed for my student:

antibiotic ointments (Bacitracin) ☐ yes ☐ no anti-itch creams/gels ☐ yes ☐ no

burn cream(gel)/topical lidocaine ☐ yes ☐ no oral pain relief (Orajel) ☐ yes ☐ no

rewetting eye drops ☐ yes ☐ no cough drops ☐ yes ☐ no

* If school policy allows and the medications are available in the Health Office, do you authorize the Health Office to administer the following oral medications?

Acetaminophen(Tylenol) ☐ yes ☐ no Ibuprofen(Advil, Motrin) ☐ yes ☐ no

Diphenhydramine(Benadryl) ☐ yes ☐ no Cetirizine (Zyrtec) ☐ yes ☐ no

Calcium Carbonate (Tums) ☐ yes ☐ no

Students Grades 7-12 only

* I authorize my student to have on them and self-administer small amounts of over-the-counter medications for their personal use. The student must keep the medication in its original container and use the medication responsibly in accordance to the label. Medications cannot list ephedrine or pseudoephedrine as the only or the primary active ingredient. Liquid cold medications are not permitted to be carried by the student. Cannabis (CBD, THC) containing products are prohibited. I understand that the school district may revoke a student's privilege to possess and use non-prescription medications if the district determines that the student is abusing the privilege. ☐ yes ☐ no

PARENT/GUARDIAN SIGNATURE_____DATE_____