

STUDENT HEALTH AND INFORMATION FORM

Garfield Skills Center

Livonia Public Schools

Name: _____

Birthdate: _____

Allergies: ☐ Yes ☐ No Allergic ☐ Be ☐ Wa ☐s Pe ☐uts ☐Dust ☐Paint ☐Plants ☐Perfume ☐Chemicals
Other _____

Uses Epi-Pen: ☐ Yes ☐ No Others: _____

If an allergen is ingested or he/she comes in contact with it, what is the reaction? (i.e.: swelling, a rash, trouble breathing, upset stomach, etc.) _____

Special Instructions: _____

Medications: ☐ Yes ☐ No (Please include: Epi-Pens, inhalers, and insulin.)

Medication Authorization form completed and signed by: Parent/guardian ☐ Yes ☐ No Physician ☐ Yes ☐ No

(This includes over the counter medications)

Medication	Medication For	Medication Dose	Takes Medication at:
_____	_____	_____	☐ Home ☐ School ☐ Both
_____	_____	_____	☐ Home ☐ School ☐ Both
_____	_____	_____	☐ Home ☐ School ☐ Both
_____	_____	_____	☐ Home ☐ School ☐ Both
_____	_____	_____	☐ Home ☐ School ☐ Both
_____	_____	_____	☐ Home ☐ School ☐ Both

PLEASE NOTE: Administration of Medication Within Schools:

If it is absolutely essential that medication be administered, we must adhere to the school code of the State of Michigan, which requires that the school office have a Medication Authorization form on file. This form must show the name of the student to receive the medication, the type of medication, the dosage and the time(s) the medication is to be given. This form also requires the Physician's signature, as well as the signature of the parent/guardian. The Medication Authorization form is available in the school office and on the Livonia Public Schools website (www.livoniapublicschools.org). ALL medications must be in the original container with prescription information on the label. We cannot administer medication that is provided in other containers or packages. A NEW AUTHORIZATION IS REQUIRED EACH YEAR.

Seizures: ☐ Yes ☐ No Type: _____

What precipitates one: _____ Expected duration: _____

Special Instructions: _____

Diabetic: ☐ Yes ☐ No Controlled by: ☐ Diet ☐ Oral Medication ☐ Insulin Insulin by: ☐ Injection ☐ Pump

Special Instructions: _____

Asthma: ☐ Yes ☐ No Special Instructions: _____

Fitness Information: Student is restricted from the following – check all that apply:

☐ Brisk Walking ☐ Running ☐ Jumping ☐ Stationary Bicycle ☐ Weightlifting ☐ Stretching

Please explain any restrictions: _____

Does the student have any of the following concerns which would exclude or limit him/her from participating in the fitness program? ☐ Heart/Circulatory ☐ Respiratory ☐ Other

If so, please explain: _____

Parent/Guardian Signature _____

Student Signature _____

Date _____