ST. BERNARD PARISH SCHOOL BOARD
STATE OF LOUISIANA

HEALTH INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN EACH SCHOOL YEAR

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE. Parent/Legal Guardian is encouraged to participate in the development of an Individual Health Care Plan if needed. Use additional sheets, if necessary, for further explanation.

Name of School:			Grade:	
Student's Name: Last		First		M.I.
Student's Date of Birth:	Sex: ☐ M ☐ F		State or Country of Birth:	
Student's Mailing Address:	City:		State:	Zip Code:
Student's Physical Address:	City:		State:	Zip Code:

Name of Mother or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:
Name of Father or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:

Name of child's pediatrician or primary care provider:	Names of medical specialists or special clinics caring for your child:

_____
Parent or Legal Guardian Signature Date

Please check the type of health insurance your child has: ☐ Private ☐ Medicaid/LaCHIP ☐ None
If your child does not have health insurance, would you like information on no cost health insurance? ☐ Yes ☐ No

In case of emergency—if parent or legal guardian cannot be reached—contact the following:
Name Complete Phone Number ( )

My child has a medical, mental, or behavioral condition that may affect his/her school day: ☐ No ☐ Yes (If yes, please complete Part 2.)

PART 2: COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD. Parent/Legal Guardian is responsible for providing the school with any medication and may be responsible for providing the school with any special food or equipment that the student will require during the school day. Check with the school nurse to obtain correct medication and procedure forms.

❑ **ALLERGIES**

Allergy Type:
- ☐ Food (list food(s)) _____
- ☐ Insect sting (list insect(s)) _____
- ☐ Medication (list medication(s)) _____
- ☐ Other (list) _____

Reactions: (Date of last occurrence if yes.)
- ☐ Coughing (Date:) ☐ Hives (Date:) ☐ Rash (Date:)
- ☐ Difficulty breathing (Date:) ☐ Local swelling (Date:) ☐ Wheezing (Date:)
- ☐ Generalized swelling (Date:) ☐ Nausea (Date:) ☐ Other _____ (Date:)

Currently prescribed medications and treatments:
☐ Oral antihistamine(Benadryl, etc.) ☐ Epi-pen ☐ Other _____

❑ **ASTHMA**

Triggers: ☐ Environmental (i.e., tobacco, dust, pets, pollen, etc.) (list) _____ ☐ Other (list) _____
Does your child experience asthma symptoms with exercise? ☐ No ☐ Yes
Symptoms:
☐ Chest tightness, discomfort, or pain ☐ Difficulty breathing ☐ Coughing ☐ Wheezing ☐ Other _____
Currently prescribed medications and treatments: _____
_____
Date of last hospitalization related to asthma _____ Date of last emergency room visit related to asthma _____
Does your child have a written asthma management plan? ☐ No ☐ Yes
Is peak flow monitoring used? ☐ No ☐ Yes

Name: _____ DOB: _____

❑ **DIABETES**

Currently prescribed medications and treatments:

☐ Insulin: ☐ Syringe ☐ Pen ☐ Pump
☐ Blood sugar testing
☐ Glucagon
☐ Oral medication(s) List medication(s) _____

Is special scheduling of lunch or Physical Education required? ☐ No ☐ Yes

❑ **SEIZURE DISORDER**

Type of seizure:

☐ Absence (staring, unresponsive) ☐ Complex Partial ☐ Generalized Tonic-Clonic (Grand Mal/Convulsive)
☐ Other (explain) _____

Physical Education Restrictions: ☐ No ☐ Yes

Medication(s): ☐ No ☐ Yes List medication(s) _____

Date of last seizure _____ Length of seizure _____

❑ **OTHER HEALTH CONDITIONS**

☐ Anemia ☐ ADD/ADHD ☐ Cancer ☐ Cerebral Palsy ☐ Chicken Pox ☐ Cystic Fibrosis
☐ Depression ☐ Digestive disorders ☐ Emotional/Psychological ☐ Juvenile Rheumatoid Arthritis
☐ Hemophilia ☐ Heart condition ☐ Physical disability ☐ Sickle Cell Disease ☐ Skin disorders
☐ Speech problems ☐ Other (explain)_____

Physical Education Restrictions: ☐ No ☐ Yes (explain): _____

Medication(s): ☐ No ☐ Yes List medication(s) _____

Special procedures required (i.e., catheterization, oxygen, gastrostomy care, tracheostomy care, suctioning): ☐ No ☐ Yes (explain):_____

Special diet required (i.e., blended, soft, low salt, low fat, liquid supplement): ☐ No ☐ Yes (explain): _____

Are there anticipated frequent absences or hospitalizations? No Yes
(explain):_____

❑ **VISION CONDITIONS**

☐ Contacts/glasses
☐ Other _____

❑ **HEARING CONDITIONS**

☐ Hearing aid(s)
☐ Other _____

❑ **ENVIRONMENTAL ADJUSTMENTS DUE TO A HEALTH CONDITION**

Special school environmental adjustments of the school environment or schedule: ☐ No ☐ Yes (explain):_____

(i.e., seizures, limitations in physical activity, periodic breaks for endurance, part-time schedule, building modifications for access)

Special school environmental adjustments to classroom or school facilities: ☐ No ☐ Yes (explain):_____

(i.e., temperature control, refrigeration/medication storage, availability of running water)

Special safety considerations: ☐ No ☐ Yes (explain):_____

(i.e., special precautions in lifting, positioning, special transportation emergency plan, special safety equipment, special techniques for positioning, feeding)

Special assistance with activities of daily living: ☐ No ☐ Yes (explain):_____

(i.e., eating, toileting, walking)

PART 3: SCHOOL NURSE TO COMPLETE if parent/legal guardian indicates medical condition.

_____ _____
School Nurse Signature Date

Notes:

RETURN COMPLETED FORM TO SCHOOL NURSE/HEALTH OFFICE AS SOON AS POSSIBLE