Little Falls Community School
Health Services

School Year ___/___

Confidential Health Form **This is a required document**

Student Name_____ Birthdate____/____/____ School_____ Teacher/Advisor_____Grade_____
Health Care Provider/Clinic Name_____
Health Care Specialists (neurology, behavioral, orthopedic, etc.) ClinicName(s)_____

☐ **My child has no health concerns**

Check any current health condition listed below about which the school should be aware:

☐ Seizures/Epilepsy:_____ Emergency Medication: Yes or No
☐ Diabetes: Insulin pump Pen CGM Life
☐ Life Threatening Allergy: _____ EpiPen Benadryl Other:
☐ Food Intolerance/Sensitivity: _____ Reaction:_____
☐ Asthma: Inhaler Nebulizer
☐ Bladder/Bowel concerns or Modifications needed: Please List_____
☐ Recent Surgery/Hospitalization; Please List_____
☐ Other (Sickle Cell, Hemophilia, Adrenal Insufficiency, Tube Feeding, Catheterization, Cardiac, Visual Impairment, Kidney, Central Line, Private Duty Nurse, etc):_____

If your child has one of the above conditions, please contact the Licensed School Nurse/District Nurse and your child's health care provider for medication authorization and emergency action plan. Health Office Notified LSN Date:___/___/___Intials____ LSN Review Date__/__/__ Intials____

☐ ADHD
☐ Anxiety
☐ Autism
☐ Concussion: Date _____
☐ Depression
☐ Ear Tubes: Placement Date _____
☐ Headaches/Migraines
☐ Orthopedic/Activity Restrictions: Please List _____
☐ Seasonal/Environmental Allergies
☐ Hearing Aids
☐ Vision: Glasses Contacts
☐ Does your child have any disabilities, physical limitations, developmental delays or sensory concerns? Yes or No If YES, please explain:

_____

Medications; List **ALL** medications that this student takes daily or as needed, this includes over the counter medications. (use reverse side if necessary)

Medication Name and Dose	Reason for Medication	Taken Daily/Time(s)	Taken as Daily

Annual written consent to dispense medication is required. Medication given at school must be brought to school by the parent in a pharmacy labeled bottle. The above information may be shared with staff.

Parent/Guardian Consent to Share Immunization Information: Your child's school is asking your permission to share your child's immunization record with Minnesota's Immunization registry to help us better protect students from disease. This is a voluntary consent. All information is considered private data and can only be released with authorization.

I agree to allow school personnel to share my student's immunizations record with Minnesota's Immunization Registry.

☐ I Do Authorize
☐ I Do Not Authorize

Please provide a complete list of child's immunizations upon entrance to Kindergarten, Grade 7, Grade 12, and new students to the district.

Parent/Guardian Signature_____Date_____

CONTACT INFORMATION FOR YOUR CHILD'S HEALTH/NURSE'S OFFICE

Early Childhood Center	Lincoln Elementary	Lindbergh Elementary	Middle School	High School
(320) 616-6220	(320) 616-6220	(320) 616-3220	(320) 616-4204	(320) 616-2208