



Little Falls Community Schools

Health Services

School year 2026/2027

Student Name _____ Birthdate _____ School _____

Health Care Provider _____ Health Care Specialist(neurology, psychiatry, etc) _____

☐ **My student 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 Threatening Allergy: _____ Epi Pen / Benadryl / Other

☐ Food Intolerance/Sensitivity: _____ Reaction: _____

☐ Asthma: Inhaler / Nebulizer

☐ Other (bladder/bowel concerns. tube feeding, cardiac, kidney, etc): _____

If your student has one of the above conditions, please contact the school nurse for required forms.

☐ ADHD

☐ Anxiety

☐ Autism

☐ Depression

☐ Headaches/Migraines

☐ Other _____

☐ Orthopedic/Activity Restrictions _____

☐ Seasonal/Environmental Allergies

☐ Hearing Aides

☐ Vision: Glasses / Contacts

☐ Does your student have any disabilities, physical limitations, developmental delays or sensory concerns?

Medications: List **ALL** medications that the student takes daily or as needed. This includes over the counter medications.
Use the reverse side as needed.

Medication Name and Dose	Reason for medication	When Taken

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 will be shared with staff as needed.

Please provide a complete list of immunizations upon entrance to Kindergarten, 7th grade and 12th grade.

Parent/Guardian Signature: _____ Date: _____

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

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