NORTH LAMAR INDEPENDENT SCHOOL DISTRICT

Student Health Information

Campus/Teacher _____ Student Name _____

Grade _____ School Year _____ Gender Male _____Female _____ Date of Birth_____/_____/_____

Address _____ City _____ Zip _____

Last School Attended _____ City _____ State _____

Resides With (Name) _____Relationship to Student _____

Place of Employment _____ Email Address _____

Phone # Home _____ Cell _____ Work _____

Parent or Guardian: To help your child in case of ACCIDENT or SUDDEN ILLNESS, WE MUST HAVE the following contacts for emergencies in the EVENT YOU CANNOT BE REACHED.

Name _____ Phone # _____

Place of Employment _____ Work # _____

Name _____ Phone # _____

Place of Employment _____ Work # _____

EpiPens are available on every campus and may be used in an emergency. STUDENTS WITH KNOWN ALLERGIES MUST PROVIDE THEIR OWN EPI-PEN. School Epi-Pens do not leave campus and will not be available on field trips.

I give permission for North Lamar School Officials to administer first-aid to my child and to transport him/her to a medical facility in case of emergency and parent/guardian cannot be reached. I will not hold the school district financially responsible for the emergency care and/or transportation for said child. By signing this form, I give permission for health information to be disclosed to those who have my child in their care. I also give permission for my child's immunization records to be released to/from other school districts.

_____ _____

Parent/Guardian Signature Date

Please complete backside of health form.

In order to take care of your child in your absence, please provide the following health information. Has he/she had any of the following?

ALLERGIES:

Food _____ Type _____ Reaction _____ Treatment _____

Latex _____ Reaction _____ Treatment _____

Stings _____ Type _____ Reaction _____ Treatment _____

Has this allergy been diagnosed by a Doctor? _____ (If yes, you must provide documentation from his/her Doctor)

NOTE: If you list a medication as the treatment, you must supply it and complete a medication form. If you have checked an allergy, please list reaction and treatment.

Asthma _____ Medication prescribed _____ Will your child be carrying an inhaler during the school day _____ (A medication form must be completed and turned in to your school nurse)

ADD/ADHD _____ Blood Disorder _____ Cancer _____ Cerebral Palsy _____ Cystic Fibrosis _____

Diabetes _____ Eating Disorder _____ Genetic Disorder _____ Headaches/Migraines _____

Hearing problems and/or hearing aids _____ Psychiatric/Psychological _____ Spina Bifida _____

Muscular/Orthopedic Disorder _____

Heart Problems _____ Type _____ Restrictions _____ Medications _____

Seizure Disorder _____ Type _____ Date of last seizure _____ Medications _____

Kidney Bladder Disorder _____ Type _____

Vision Correction _____ Glasses _____ Contacts _____

Other

_____

List all medications student is currently taking at home and/or at school.

Medication name _____ Dose & Frequency _____ Reason _____

Medication name _____ Dose & Frequency _____ Reason _____

Medication name _____ Dose & Frequency _____ Reason _____

Medication name _____ Dose & Frequency _____ Reason _____

Please give any additional information that you feel we need in order to meet your child's needs

_____

_____

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