Lonoke School District

Student Health Form

Date: _______________ Allergies: ________________________________

Student Name: ____ Date of Birth: _______________ Grade: ______

Parent/Guardian 1: ____ Cell Phone #: __________________

Parent/Guardian 2: ____ Cell Phone #: __________________

Emergency Contact: ______________________________________ Cell Phone #: __________________

Physician Name: ____ Phone #: _______________________

Preferred Hospital: ACH Baptist Springhill-NLR Baptist-LR

Insurance: ____ Mediaid: ________________________________

CURRENT HEALTH CONCERNS:

Please mark any of the following health concerns that may impact the student's educational day.
This information may be shared with LPSD staff as appropriate.

EPI-PEN prescribed: Yes or No Allergy to: Food: ________________________ Insect/Bee/Wasp: _________________
Environmental: _____________________ Medication: _____________________ Other: ___________________________

SEIZURES: Yes or No Type of seizures: ________________________________ Date of last seizure: ______________
Diastat prescribed for seizures: Yes or No

ASTHMA: Yes or No Inhaler type: ________________________________ Nebulizer: __________________________
(Asthma Action Plan signed by the prescribing physician must be turned in with an inhaler to the school nurse.)

DIABETES: Yes or No Medications: ____

HEART PROBLEMS: Yes or No Explain: ____

VISION PROBLEMS: Yes or No Glasses: Yes or No Date of last eye exam: _________

HEARING PROBLEMS: Yes or No Hearing aids: Yes or No Date of last exam: _________

CANCER: Yes or No Type: ____

CEREBRAL PALSY: Yes or No _____________________ PHYSICAL DISABILITY: Yes or No ____________________

MENTAL HEALTH ISSUES: Yes or No ____

NEUROLOGICAL ISSUES: Yes or No ____

MEDICATIONS: (Please list all medications your child takes on a routine basis) 1) ______________________________
2) ________________________________ 3) _________________________________ 4) ______________________________
Other: ____

Unless a specific time of day is required or a medication is to be given more than 4 times a day it should be given at home. All prescription medications must be provided by parents and brought to the school for a medication form to be filled out and signed by the parents before it can be administered by the school nurse. The first dose of any medication must be given at home.

NOSE BLEEDS: Yes or No Frequency: _____________________

BOWEL or BLADDER PROBLEMS: Yes or No Explain: ____

OTHER HEALTH PROBLEMS: ____

Lonoke School District

Student Health Form

Over the counter medication will only be given five (5) times in a semester. Greater than five (5) times must have a Doctor's order with a diagnosis. The over the counter medication will need to be provided from home. (This is to prevent over usage of over the counter medication, that can cause unintended adverse effects)

I give my permission for the following:

- **My child to be transported by ambulance in an emergency Yes or No**
- **My child to be transported to a local doctor's office for urgent care Yes or No**
- **My child to receive oral medication for minor illnesses: Tylenol, Tums, Cough drops, Orajel, Chloraseptic Spray, Children's Cough and Cold for nasal congestion, Claritin (Loratadine), Zyrtec (Cetirizine) for allergies. Yes or No**

No child is to have medication in their possession; this is not permitted at all at Primary and Elementary School. Middle School and High School parents may fill out a self-carry form in approved situations. (You have to pick up a form from the nurse. The parents must complete the form. The form must be approved and signed by your doctor. The administration/nurse has the right to revoke this if the student shows irresponsible behavior or there is a safety risk)

I agree for my child to:

- **Receive first aid or topical treatment for minor injuries or skin disorders if needed (antibiotic ointment, alcohol prep, hydrogen peroxide, bandages, calamine, Solar Caine or dermoplast for minor sun burns, itch cream, etc.) Yes or No**
- **Receive eye wash solution to remove foreign body such as dust from eyes. Yes or No**
- **Receive Benadryl if signs and symptoms of an allergic reaction present. Yes or No**
- **To participate in the following screenings: Height/Weight (Act 1220 of 2003) and Scoliosis (Act 95 of 1987) Yes or No**

I will not hold Lonoke Public Schools financially responsible for the emergency care and/or transportation of my child for medical attention. In order to facilitate health care, I understand the above information may be released to the appropriate Lonoke School District employees and emergency personnel.

Parent/Guardian Name (Please Print): ______________________________

Signature of Parent/Guardian: ______________________________ Date: ______________

Nurse Name: (Please Print): ______________________________

Signature of Nurse: ______________________________ Date: ______________