LENNOX SCHOOL DISTRICT 41-4 HEALTH FORM

EACH student in Lennox School District should have a current Health form on file. The information on these sheets will be treated as CONFIDENTIAL information and be shared only with other personnel as needed. Please fill out this form completely. If the child has No Known Health Problems or Allergies please check the appropriate blanks.

Student Name_____ **Birth date** _____
Grade and Teacher _____ **School Attendance Site**_____
Parent Name(s):_____**Phone # (s)**_____

Allergies: Check all that apply. Explain the type of reaction and if treatment is needed.
_____ Food (specify) _____
_____Medication _____
_____Insect Stings_____
_____Seasonal Allergies_____
_____Other_____
__ **No Known Allergies**

Health History: Please check all that apply.

_____ **NO KNOWN HEALTH PROBLEMS**
_____ Cardiac (specify below)
_____ Diabetes
_____ Seizures/Convulsions
_____ADD_____ADHD
On Medication- YES/NO (please circle)
_____Asthma
__ Mental Health/Emotional/
Behavioral – (specify below)
_____Other Medical Conditions (specify below)

_____ Stomachaches
_____ Skin (specify below)
_____ Headaches
___ Vision
glasses/ contacts (please circle)
_____ Hearing Condition/Disorder (infections, tubes)
Hearing Aid: ___Right ___Left
_____ Bowel/Bladder Incontinence **Please send a change of clothes to keep at school.

Comments/ Special Classroom Considerations: _____
_____
_____

Medications—Please list any medications (name, dosage, frequency, time) your child is currently taking:
_____
_____

Will your child be taking medication at school? If yes, a Medication Permission form must be filled out at the beginning of the school year.
_____Yes _____No

Special Diet Requested: If yes, a special food diet form must be filled out by your child's physician and be on file with the school.
_____Yes _____No

In case of emergency- if parents aren't available, who should be contacted?
Name: _____ Phone #_____ Cell #_____
Name: _____ Phone #_____ Cell #_____

Emergency Medical Consent

In the event that my child may require medical and /or surgical care while I am out of town or unable to be reached, I hereby give my consent to medical and/or surgical treatment to _____ Hospital and Doctor _____Phone_____Address_____ or his/her designee to provide care. I agree to pay all costs and fees contingent on any emergency medical care and/or treatment for my child or authorized under this consent. (Every effort will be made to notify parents/guardians in case of an emergency).

Parent Signature: _____