Lowell Area Schools - Health History Form

School Year:

Parents: The information provided here is essential so that schools can be properly prepared to take care of any special health needs your child may have during the school day. This information will be guarded with confidentiality and only shared with school personnel as necessary. Please keep this information up to date. Staff conferences may be required or can be requested by parent/guardian depending on the nature/severity of the health condition.

Student Name:

Grade: **Date of Birth:** **School:**

Please indicate any diagnosed medical conditions: *(Conditions not diagnosed by a physician should not be included)*

Health Conditions I. If a condition is indicated below, an ***Emergency Action Plan*** will need to be signed by both the health care provider and the parent/guardian.	**Health Conditions II.** If your student requires medication to be taken at school for any of the following conditions, you will need to include a medication form.	**Health Conditions III.** If your student requires medication to be taken at school for any of the following conditions, you will need to include a medication form.
Allergies Epi Pen? Asthma Inhaler in Office Self-Carry Inhaler Seizure Disorder	Bowel/Bladder Concerns Cancer Cerebral Palsy Cystic Fibrosis Diabetes Headaches/Migraines Heart/Lung Condition Special Diet	Depression Anxiety Other mental Health Condition Eating Disorder ADD/ADHD Visually Impaired Hearing Impaired

Skilled Procedures:
Tube Feeding Catheterization Tracheostomy/Suctioning Other

Other diagnosed medical conditions not listed above:

Physical Restrictions (Physicians note required):

Medications Required at school:

Parent/Guardian signature: _____

Receiving staff Signature: _____ Date: _____

For Office Use Only: RN Initials_____ DIR Initials_____ Completed Date:_____