Laquey R-5 School District STUDENT HEALTH HISTORY School Year _____-_____

Student Name: _____ DOB: _____ Grade: _____ M_____ F_____
Address: _____
Father Name/Phone Number: _____
Mother Name/Phone Number: _____
Student Lives With/Relationship: _____

IN CASE OF AN EMERGENCY OR SUDDEN ILLNESS, PLEASE LIST TWO PEOPLE WITH CURRENT PHONE NUMBERS WHOM THE SCHOOL CAN CONTACT IN THE EVENT YOU CANNOT BE REACHED (PLEASE DO NOT LIST YOURSELF)
NAME/RELATIONSHIP/PHONE NUMBER: _____
NAME/RELATIONSHIP/PHONE NUMBER: _____

Does your child have any health problems? (Check those that apply.)
ADD____ ADHD____ AUTISM____ ASTHMA____ SEASONAL ALLERGIES____ SEVERE FOOD ALLERGY____
BEE/WASP STING ALLERGY_____ DIABETES_____ HEART____ SEIZURES_____ ECZEMA____ OTHER____
(PLEASE EXPLAIN OTHER) _____

Does your child have any hearing/vision issues? _____
Does your child take any routine medications? _____
_____
Does your child have any food/drug allergies? (If so, please indicate if Epi-Pen is ordered.) _____
_____
Type of Health Insurance: MC+/Medicaid____ Private____ Employment____ None____
Date of Last Physical: _____ Primary Care Doctor: _____
Date of last Dental Exam: _____ Primary Care Dentist: _____
Has your child been hospitalized/had a serious injury in the past year? _____
_____

If it is necessary to take prescription medication during school hours, proper forms must be completed and signed by the parent or guardian. All medication must come in the original container with the prescription label. **ANY MEDICATION SENT TO SCHOOL IN ANYTHING OTHER THAN ORIGINAL CONTAINER WILL NOT BE DISPENSED AND WILL BE KEPT BY THE NURSE UNTIL AN ADULT PICKS IT UP. INHALERS NEED TO COME IN THE BOX WITH THE PRESCRIPTION LABEL. COUGH DROPS ARE CONSIDERED A MEDICATION. PLEASE DO NOT SEND IN YOUR CHILD'S BACKPACK. ALL MEDICATIONS NOT PICKED UP BY THE END OF THE SCHOOL YEAR BY AN ADULT WILL BE DISPOSED OF ACCORDING TO PROTOCOL.**

In an attempt to help students remain in school and function at their best, the nurse may dispense some OTC medication with your permission. Please check the appropriate boxes and sign/date below. **I AUTHORIZE LAQUEY R-V SCHOOL DISTRICT TO ADMINISTER THE FOLLOWING MEDICATIONS TO MY CHILD.**

____ACETAMINOPHEN (TYLENOL) ____IBUPROFEN (MOTRIN) _____ANTACIDS (TUMS)
____COUPH DROPS (CHERRY OR MINT) ____THROAT LOZENGES
____ORAJEL/ANBESOL ____EYE DROPS ____BENADRYL 25 mg (Generic) ____BENADRYL 12.5 mg (Generic)
____ANTIBIOTIC TOPICAL (TRIPLE ANTIBIOTIC OINTMENT, BACITRACIN)
____ANTI-ITCH TOPICALS (HYDORCORTISONE CREAM, CALAMINE, ETC.)

If your student has a medical condition requiring medication/treatment during school hours, do we have your consent to exchange information with your child's doctor's office as needed?
Signature: _____

EMERGENCY CARE AUTHORIZATION: I/WE THE UNDERSIGNED AUTHORIZE OFFICIALS AT LAQUEY R-5 SCHOOL DISTRICT TO TAKE WHATEVER ACTION DEEMED NECESSARY FOR THE HEALTH AND WELL-BEING OF THE AFOREMENTIONED CHILD. THIS IS TO INCLUDE EMERGENCY TRANSPORTATION AND TREATMENT. (PLEASE INITIAL HERE) _____

_____ _____
Parent/Guardian Signature Date