2025-26 LNS ANNUAL STUDENT HEALTH INFORMATION DOCUMENT

Student Name: _____Date of Birth:_____ School Year: _____ Grade: _____

Does your child have a health condition? ❑ Yes ❑ No

(Please provide detail below. May need to contact School Nurse and form a health plan prior to attending school.)

Does your child need to take medication at school? ❑ Yes ❑ No

(An *Authorization for Administration of Medication at School* is required and must be updated annually.)

Is your child up to date on immunizations? ❑ Yes ❑ No

(Per Policy 4340 students will be excluded until current vaccination **or** exemption paperwork is provided.)

LIFE-THREATENING HEALTH CONDITIONS: A healthcare plan with guardian signature, healthcare provider signature, and all medications must be in place and updated **ANNUALLY** before the student can attend school. (See policy 4350.)

- ❑ **Life-Threatening allergy requiring epinephrine auto injector (EpiPen)**
  Life Threatening Allergen(s): _____
- ❑ **Asthma:** Inhaler needed at school? ❑ **Yes** ❑ **No** Student Permitted to self-carry inhaler? ❑ **Yes** ❑ **No**
  List symptoms and/or Triggers: _____
- ❑ **Diabetes Type** ____ My child has: ❑ insulin pump ❑ insulin pen ❑ insulin vial/syringe ❑ oral medication
- ❑ **Seizure Disorder** Meds used to control seizures: _____ Last seizure on: _____
- ❑ **Other life-threatening condition(s):** _____

_____

HEALTH CONDITIONS: Check any of these conditions which your child has or has had:

❑ **Heart Problems** : _____	❑ **Cancer:** _____
❑ **Neuro / Brain Injury** :_____	❑ **Blood Disorder:** _____
❑ **Hearing:** _____	❑ **Muscles/Bones:** _____
❑ **Vision:** _____	❑ **Developmental Condition:** _____
❑ **ADD / ADHD:** Medication at school? ❑ Yes ❑ No	❑ **Other:** (please explain) _____
_____	_____

SPECIAL HEALTHCARE PLANNING: Check appropriate boxes and contact your school nurse for a health care plan. Treatment order from the doctor is required for most special health care needs other than mobility aids.

- ❑ **Dietary/ Food Intolerance** (non life-threatening)**:**_____
- ❑ **Special Health Care Planning,** (i.e., tube feeding; treatment order required.) Please describe**:** _____
- ❑ **Mobility Aids** (i.e., wheelchair, walker): _____

Please note: The above health information may be shared with school personnel on a "need to know" basis.

Authorization for Emergency Procedure If the guardians named on the registration record cannot be reached at the time of an emergency, and the illness, injury or impairment is determined to be urgent by school authorities/school nurse, I authorize and direct the school authorities to send the student (properly accompanied) to the hospital or doctor most easily accessible. I understand that I will assume full responsibility for the payment of any services rendered.

Guardian Signature: _____ **Date:** _____