LAKEVILLE AREA PUBLIC SCHOOLS ISD 194
STUDENT HEALTH INVENTORY

Student name- last, first, middle **Sex** **Birth date** **School** **Grade**

This information is needed to keep your child healthy and safe at school. If your child has a life threatening health condition; it is the parent/guardian's responsibility to notify the school nurse prior to school attendance so that an appropriate plan of care is developed.

HAS YOUR CHILD BEEN DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER WITH ANY OF THE FOLLOWING: CIRCLE &/OR CHECK "YES" OR "NO", THEN EXPLAIN ALL "YES" ANSWERS

DOES YOUR CHILD HAVE?	YES	NO	EXPLANATION
ADD/ ADHD medication? dose?			
Allergies: drugs, foods, insects, latex?			
Arthritis or joint pain			
Asthma, mild moderate severe meds?			
Autism			
Birth defects			
Bladder concerns			
Bleeding disorder: type?			
Brain injury/ unconsciousness?			
Cancer: type? Remission?			
Cerebral palsy: identify type/limbs			
Cystic Fibrosis			
Depression: medication/counseling?			
Developmental delays			
Diabetes: age at diagnosis?			
Dietary restrictions			
Down's Syndrome			
Ear or hearing concerns			
Eating disorder: over/ underweight			
Emotional or psychological concern			
Eye or vision concerns			
Heart condition: restrictions?			
Intestinal/bowel concerns: soiling?			
Kidney disease			
Migraines or severe headaches			
Prematurity: weeks? Apgars?			
Seizures: type, meds, last seizure?			
Skin concerns			
Speech/communication concerns			
Spina bifida			

OVER

CONFIDENTIAL

Student name _____

HAS YOUR CHILD HAD? **SPECIFY TYPE AND DATE**

Serious Injury? NO YES _____
Serious Illness? NO YES _____
Surgery? (Operation) NO YES _____
Chemical health treatment? NO YES _____
Mental health treatment? NO YES _____

Does your child have any other specific illness, disability or limiting condition? Explain: _____
_____

DOES YOUR CHILD	**YES**	**NO**	**EXPLAIN or CIRCLE**
Wear glasses?			Distance Reading
Wear contacts?			Distance Reading
Wear an eye patch?			Left Eye Right Eye
Wear hearing aides?			Left Ear Right Ear
Require medical procedures or adaptive equipment at home/school?			
Have physical or medical limitations?			
Have a condition that prevents full participation in PE?			
Receive therapies or treatments?			
Wear diapers?			
Have condition requiring emergency treatment/meds at school?			

Has your child ever taken medication for an extended period of time? YES NO
If yes, please explain_____

Does child currently take any medications? YES NO If yes, please complete

Medication	**Dose**	**Time(s)**	**Reason**	**Side effects**	**Prescribing Physician**

ISD 194 requires written authorization from a licensed health care provider and parent before medication, prescription or over the counter, may be taken at school.

Do you have concerns about your child's physical health, behavior or emotional well being? _____
_____

Would you like to discuss your child's health, emotional well- being or behavior with school staff?
Please circle: Licensed School Nurse Teacher Counselor Principal

I understand that the information provided above will be shared in a confidential manner with appropriate staff members who need to know in order to provide for the health needs and safety of my student. I will keep the school informed of any changes in health status or contact information. Information provided on this form is true and accurate.

Parent//Guardian Signature: _____*date*_____

LSN Signature: _____*date*_____