2020-2021

STUDENT HEALTH FORM

Lakeview Public School District #2167
P O Box 107, 875 Barstad Road,
Cottonwood, MN 56229
Phone: (507) 423-5164 Ext. #1154   Fax: (507) 423-6198

STUDENT NAME ____ BIRTHDATE____________________
LAST FIRST MI

☐MALE ☐FEMALE GRADE: Pre-K K 1 2 3 4 5 6 7 8 9 10 11 12 TEACHER: ______________________________

PARENT/GUARDIAN NAME______________________________DAYTIME PHONE NUMBER _________________
(please update on ParentVue)

EMERGENCY CONTACT___________________________________RELATIONSHIP______________________

DAYTIME PHONE NUMBER____

PRIMARY PHYSICIAN or CLINIC______________________________________PHONE_____________________

HEALTH HISTORY:

Please put an (x) if the student has any history of the following conditions: ☐ **NO HEALTH HISTORY**

☐ **ADHD/ADD:** Medication: ___________________________________ Prescribing Doctor__________________

☐ **ALLERGIES-*SEE NURSE*** ☐FOOD ☐MEDICATION ☐LATEX ☐BEE STINGS ☐SEASONAL ☐OTHER: __________________

____

LIFE THREATENING:

☐YES ☐NO EPI PEN: ☐YES ☐NO AVAILABLE IN SCHOOL: ☐YES (SELF-CARRIES☐ NURSE OFFICE☐) ☐NO

MEDICATION: ____

☐**ASTHMA-*SEE NURSE*** or other breathing problems: ____

____

1. Has the student ever been diagnosed by a medical provider as having asthma? ☐YES ☐NO
2. Does the student take medication for asthma? (If yes, please list on back) ☐YES ☐NO
3. Has the student had an episode(s) of wheezing in the last 12 months? ☐YES ☐NO
4. In the last 12 months have you heard the student wheeze or cough after active playing? ☐YES ☐NO
5. If the student has asthma and/or other breathing problems and uses an inhaler will the student carry and self-administer the inhaler? ☐YES ☐NO
6. Other breathing problems____

☐**BLADDER/BOWEL PROBLEMS**: ____

☐**CHICKENPOX** (date)____

☐**DIABETES-*SEE NURSE*** ____

☐**EAR PROBLEMS**____

☐**EYE PROBLEMS** ____

☐**HEADACHES/MIGRAINES**____

☐**HEALTH PROBLEMS NOT OTHERWISE IDENTIFIED**_____________________________________

☐**HEART CONDITION** ____

☐**MENTAL HEALTH/EMOTIONAL/SOCIAL/BEHAVIORAL CONCERNS**: ___________________________

☐ANXIETY ☐DEPRESSION ☐PANIC ATTACKS ☐SOCIAL PHOBIA ☐OTHER: ____________________________

STUDENT'S NAME____

☐**SEIZURES**: TYPE (IE; epileptic, febrile) ______________________________ DATE OF LAST SEIZURE: ________________________
☐**SKIN CONDITIONS**____
☐**STOMACH PROBLEMS**____

COMMENTS or OTHER CONCERNS:

____
____
____
____

TREATMENT/PRECAUTIONS/PLAN (INTERVENTIONS, MEDS, PARENT NOTFICATIONS)

____
____
____
____

*THE SCHOOL DOES **NOT** SUPPLY ANY MEDICATIONS. IF YOU WOULD LIKE TO KEEP A STOCK SUPPLY OF OVER THE COUNTER MEDICATIONS (TYLENOL, IBUPROFEN, COUGH DROPS) AT SCHOOL TO BE DISPENSED AT THE DISCRETION OF THE NURSE YOU MUST PROVIDE THESE AND FILL OUT A MEDICATION ADMINSTRATION FORM. THIS FORM CAN BE FOUND ON THE SCHOOL WEBSITE OR IN THE HEALTH OFFICE.

This information will be shared as appropriate with classroom and gym teachers, first responders, and/or kitchen staff if food related, etc. If only specific staff, please list who:
____
____

Please fill out a separate form for sharing medical information with the bus service.

PARENT/GUARDIAN SIGNATURE____DATE___________________

SCHOOL NURSE SIGNATURE____DATE___________________