

STATE OF LOUISIANA

HEALTH INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN EACH SCHOOL YEAR

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE. Parent/Legal Guardian is encouraged to participate in the development of an Individual Health Care Plan if needed. Use additional sheets, if necessary, for further explanation.				
Name of School:			Grade:	
Student's Name: Last		First		M.I.
Student's Date of Birth:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	State or Country of Birth:	
Student's Mailing Address:		City:	State:	Zip Code:
Student's Physical Address:		City:	State:	Zip Code:
Name of Mother or Legal Guardian:	Home Phone: ()	Work Phone: ()	Cell Phone: ()	Employer:
Name of Father or Legal Guardian:	Home Phone: ()	Work Phone: ()	Cell Phone: ()	Employer:
Name of child's pediatrician or primary care provider:		Names of medical specialists or special clinics caring for your child:		
Parent or Legal Guardian Signature _____ Date _____				
Please check the type of health insurance your child has: <input type="checkbox"/> Private <input type="checkbox"/> Medicaid/LaCHIP <input type="checkbox"/> None If your child does not have health insurance, would you like information on no cost health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				
In case of emergency—if parent or legal guardian cannot be reached—contact the following: Name _____ Complete Phone Number ()				
My child has a medical, mental, or behavioral condition that may affect his/her school day: <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please complete Part 2.)				
PART 2: COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD. Parent/Legal Guardian is responsible for providing the school with any medication and may be responsible for providing the school with any special food or equipment that the student will require during the school day. Check with the school nurse to obtain correct medication and procedure forms.				
<input type="checkbox"/> ALLERGIES				
Allergy Type: <input type="checkbox"/> Food (list food(s)) _____ <input type="checkbox"/> Insect sting (list insect(s)) _____ <input type="checkbox"/> Medication (list medication(s)) _____ <input type="checkbox"/> Other (list) _____				
Reactions: (Date of last occurrence if yes.) <input type="checkbox"/> Coughing (Date: _____) <input type="checkbox"/> Hives (Date: _____) <input type="checkbox"/> Rash (Date: _____) <input type="checkbox"/> Difficulty breathing (Date: _____) <input type="checkbox"/> Local swelling (Date: _____) <input type="checkbox"/> Wheezing (Date: _____) <input type="checkbox"/> Generalized swelling (Date: _____) <input type="checkbox"/> Nausea (Date: _____) <input type="checkbox"/> Other _____ (Date: _____)				
Currently prescribed medications and treatments: <input type="checkbox"/> Oral antihistamine (Benadryl, etc.) <input type="checkbox"/> Epi-pen <input type="checkbox"/> Other _____				
<input type="checkbox"/> ASTHMA				
Triggers: <input type="checkbox"/> Environmental (i.e., tobacco, dust, pets, pollen, etc.) (list) _____ <input type="checkbox"/> Other (list) _____ Does your child experience asthma symptoms with exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes Symptoms: <input type="checkbox"/> Chest tightness, discomfort, or pain <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Coughing <input type="checkbox"/> Wheezing <input type="checkbox"/> Other _____				
Currently prescribed medications and treatments: _____				
Date of last hospitalization related to asthma _____ Date of last emergency room visit related to asthma _____ Does your child have a written asthma management plan? <input type="checkbox"/> No <input type="checkbox"/> Yes Is peak flow monitoring used? <input type="checkbox"/> No <input type="checkbox"/> Yes				

