Lewistown School District #1
HEALTH & MEDICAL INFORMATION

STUDENT NAME:

****Please note:** Any child requiring prescription medication at school will need a health care plan and a doctor's order on file before this medication can be given at school. Complete a health history form if there are medical concerns.

Allergies to: ☐ Bee Sting ☐ Food ☐ Environment ☐ Latex ☐ Medication ☐ Other:

Please explain type of allergy:

Describe reaction and intervention:

Is an *EpiPen* necessary to control allergic reactions? ☐ Y ☐ N **If yes, I (legal guardian) will provide. Please Initial_____**

Allergy Medication currently taking:
☐ Takes medication at home ☐ **Needs medication at school

Asthma:
Name of asthma medication(s):
☐ Takes medication at home ☐ **Needs medication at school ☐ Carries inhaler on person ☐ Inhaler in school office

Attention Deficit Disorder:
Name of ADD medication(s):
☐ Takes medication at home ☐ **Needs medication at school ☐ Diagnosed but no medication

Diabetes: ☐ **Insulin dependent/needs school program set up ☐ Self manages snacks, diet, testing, coverage

Seizures:
Name of seizure medication(s):
☐ Takes medication at home ☐ **Needs medication at school ☐ History of seizure but not currently on medication

Other Prescription Medications:
Name of medications:
Diagnosis:
☐ Takes prescription medication at home ☐ **Needs prescription medication at school

Hearing Concerns:
(Please explain)

Vision Concerns:
(Please explain)

Physical Restrictions:
☐ **Uses mobility aide (wheelchair, walker etc.) ☐ **Restricted due to:
☐ Must avoid this/these activities:
(Doctor's letter is required for some P.E. adaptations)

Other: Describe health history (operations, serious accidents, and serious illness)

Diseases/Conditions: If known, please indicate the year of the disease/condition

☐ Chicken Pox	☐ Measles (Rubella)	☐ Mumps	☐ Rubella (3 day)	☐ Scarlet Fever
☐ Eczema	☐ Whooping Cough	☐ Heart Disease	☐ Rheumatic Fever	☐ Sinusitis
☐ Kidney/Bladder Disorder	☐ Congenital Condition	☐ Other (Please describe):		

MEDICAL AUTHORIZATION

Please initial_____ I certify that the above information is correct and authorize release of my child to emergency personnel in the event of an emergency.

Please initial_____ In the event my child is injured or becomes seriously ill, I hereby delegate school personnel to take emergency action as they believe necessary.

Please initial_____ I understand that it is necessary for the district to share medical information with those who are charged with the care of my child.

Please initial_____ I agree to keep school staff informed as to changes to the information so the student records can be updated as needed.

_____ _____
Parent/Guardian signature (required) *Date*