YEARLY HEALTH FORM

Student's Name _____ School Year _____ Grade/Teacher _____

Family Physician _____ Physician Phone _____

My child can participate in all activities including physical education. Yes _____ No _____

If, at any time during the school year, your child has any physical or other limitations that restrict him/her from participating in school activities, including gym, please provide medical documentation from your child's licensed care provider stating the specific restrictions and the reason for the limitations.

ASTHMA AND ALLERGIES

Asthma _____ Uses inhaler/nebulizer _____ Needs Medication at School (Yes/No) _____
Food Allergy _____ Requires Epipen/Benadryl _____
Bee Sting Allergy _____ Requires Epipen/Benadryl _____
Drug Allergy _____

List any medications taken at home or will need to take at school on a daily basis: _____
_____

- **NOTE: All medications to be taken at school require an <u>Authorization for the Administration of Medicine by School Personnel</u> order signed by a medical provider and parent/guardian.**

OTHER MEDICAL CONDITIONS

Please notify the school nurse if your child has any of the following medical conditions:

ADHD/ADD	_____	Hearing Problem	_____	Skin Disorder	_____
Cerebral Palsy	_____	Heart Condition	_____	Speech Defect	_____
Diabetes	_____	Physical Handicaps	_____	Surgery	_____
Ear Infections	_____	Scoliosis	_____	Urinary Problem	_____
Epilepsy	_____	Seizures	_____	Vision Problem	_____

If you answer "yes" to any of the above, please explain_____
_____

Please list any other medical conditions or other problems that you feel the school nurse should be aware of.
_____
_____

List dates and types of any communicable disease your child has had during the past year (ex: Rheumatic fever, Poliomyelitis, Scarlet Fever, Pneumonia, Mumps, Measles, Chicken Pox, German Measles)
_____

Does your child have health insurance? Yes _____ No _____

Name of Insurance Company _____

Would you like the above information shared with the bus company? Yes _____ No _____
Would you like the above information shared with appropriate school staff? Yes _____ No _____
I give permission for the school nurse to contact my child's physician as needed to obtain medical information. Yes _____ No _____

When your child is **ABSENT**, please call the school anytime at (860) 376-2403, ext. 203 and leave a message, including your child's name, teacher and reason why child will be out (sick, injured, family emergency, etc.). You may also email the attendance secretary at tgolas@lisbonschool.org. Otherwise, you will be called at home, cell or at work.

SCOLIOSIS SCREENINGS will be done for female students in grades 5 and 7 and male students in grade 8. The screenings will be performed in the spring. If you **DO NOT** want your child to participate in this screening at school, please check the reason below:

_____ His/Her health care provider will conduct the screening at their physical this school year.
_____ He/She is under the care of a doctor for scoliosis.

I, the undersigned, do hereby authorize officials of Lisbon School District to contact directly the persons named as emergency contacts and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child.

In the event that physicians, emergency contacts, or parents cannot be reached, the school officials are hereby authorized to take whatever action is deemed necessary in their judgement, for the health of the aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Signature of Parent/Guardian: _____ Date: _____

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