

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 Authorization for the Administration of Medicine by School Personnel 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 lsurfus@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 judgment, 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: _____