SCHOOL YEAR: _____

TERREBONNE PARISH SCHOOL DISTRICT
HEALTH INFORMATION

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.
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.

Student Name: Last First M.I.		Sex: ❑ M ❑ F	DOB:	Grade:	School:
Student's Mailing Address:		City:		State:	Zip:
Student's Physical Address:		City:		State:	Zip:
Name of Mother/Legal Guardian	Home Phone	Work Phone		Cell Phone	Employer
Name of Father/Legal Guardian	Home Phone	Work Phone		Cell Phone	Employer
Emergency Contact (other than parent/guardian)	Home Phone	Work Phone		Cell Phone	Employer
Name of pediatrician/primary care provider	Phone No	Name of medical specialists/clinics		Phone No.	

If your child does not have health insurance, would you like information on no cost health insurance? ❑ Yes ❑ No
My child is enrolled in Special Education ❑ Yes ❑ No
My child has a medical, mental, or behavioral condition that may affect his/her school day: ❑ No ❑ Yes (If yes, please have your medical care provider complete part 2)

In order to make sure my child's special health needs are met, I allow my child's information to be shared confidentially with Physicians, Physician's office staff, and professional and lay school staff as determined by the school principal and/or school nurse. This form will remain in effect for the duration of the school year unless revoked in writing by me.
I will notify the school/school nurse of any changes in my child's health or medical condition(s).

Parent/Legal Guardian Signature _____ Date_____

PART 2: MEDICAL CARE PROVIDER TO COMPLETE Please complete part 2. If medication or special procedures are needed during the student's school day, orders can be obtained from the student's school/school nurse.

❑ **ALLERGIES**
Allergy Type:
❑ Food (list food(s) _____ ❑ Medication (list medication(s) _____
❑ Insect sting (list insect(s) _____ ❑ Other: _____
Reactions: Date of last occurrence _____Describe _____
Currently prescribed medications and treatments for home: ❑ No ❑ Yes
❑ Oral antihistamine (Benadryl, etc.) ❑ Epi-pen ❑ Other _____

❑ **ASTHMA** ❑ Mild ❑ Moderate ❑ Severe
Triggers (i.e., tobacco, dust, pets, pollen, exercise etc.) (list) _____
Symptoms: ❑ Chest tightness, discomfort, or pain ❑ Difficulty breathing ❑ Coughing ❑ Wheezing ❑ Other _____
Currently prescribed medications and treatments: _____
Date of last hospitalization related to asthma _____ Date of last emergency room visit related to asthma _____
Does the student have a written asthma management plan? ❑ No ❑ Yes Is peak flow monitoring used? ❑ No ❑ Yes

❑ **DIABETES** Type:_____
Currently prescribed medications and treatments :❑ Insulin ❑ Syringe ❑ Pen ❑ Pump ❑ Blood sugar testing
❑ Glucagon ❑ Oral medication(s) List medication(s) _____
Is special scheduling of lunch or Physical Education required? ❑ No ❑ Yes: _____

STUDENT NAME: _____ DATE OF BIRTH:_____
❑ **SEIZURE DISORDER**

SCHOOL YEAR: _____

Type of seizure: ❑ Absence ❑ Generalized Tonic-Clonic (Grand Mal/Convulsive)
❑ Complex Partial ❑ Other (explain) _____
Physical Education Restrictions: ❑ No ❑ Yes (explain) _____
Medication(s): ❑ No ❑ Yes List medication(s) _____
Date of last seizure _____ Length of seizure _____

❑ **OTHER HEALTH CONDITIONS** **Chicken Pox: Date of disease:** _____

❑ Anemia	❑ Depression	❑ Hemophilia	❑ Speech problems
❑ ADD/ADHD	❑ Digestive disorders	❑ Heart condition	❑ Other (explain) _____
❑ Cancer	❑ Emotional/Psychological	❑ Physical disability	
❑ Cerebral Palsy	❑ Juvenile Rheumatoid Arthritis	❑ Sickle Cell Disease	
❑ Cystic Fibrosis		❑ Skin disorders	

Physical Education Restrictions: ❑ No ❑ Yes (explain): _____

Home Medication(s) for conditions listed above: ❑ No ❑ Yes List medication(s) _____

Restrictions/Accommodations for conditions listed above: ❑ No ❑ Yes Explain: _____

Special procedures required (i.e., catheterization, oxygen, gastrostomy care, tracheostomy care, suctioning):
❑ No ❑ Yes (explain): _____

Special diet required (i.e., blended, soft, low salt, low fat, liquid supplement): ❑ No ❑ Yes (explain): _____

Are there anticipated frequent absences or hospitalizations? ❑ No ❑ Yes
(explain): _____

❑ **VISION CONDITIONS**
❑ Contacts/glasses ❑ Other _____

❑ **HEARING CONDITIONS**
❑ Hearing aid(s) ❑ Other: _____

❑ **ENVIRONMENTAL ADJUSTMENTS DUE TO A HEALTH CONDITION**
Special adjustments of the school environment or schedule required: ❑ No ❑Yes (explain): _____
(i.e., seizures, limitations in physical activity, periodic breaks for endurance, part-time schedule, building modifications for access)
Special adjustments to classroom or school facilities required: ❑ No ❑ Yes (explain): _____
(i.e., temperature control, refrigeration/medication storage, availability of running water)
Special safety considerations required: ❑ No ❑ Yes (explain): _____
(i.e., precautions in lifting or positioning, transportation emergency plan, safety equipment, techniques for positioning or feeding)
Special assistance with activities of daily living required: ❑ No ❑ Yes (explain): _____
(i.e., eating, toileting, walking)

Medical Care Provider's Name (Printed) Address Phone and Fax Numbers

Medical Care Provider's Signature Credential (i.e. MD, NP, DDS) Date

PART 3: SCHOOL NURSE TO COMPLETE

Nurse Notes: _____

School Nurse Signature Date

RETURN COMPLETED FORM TO SCHOOL NURSE AS SOON AS POSSIBLE