Lakewood School District

School ___________________________School Year ________________

HEALTH CONCERNS

To be completed by a parent/guardian

Student Name: ____________________________ **Birth date:** ___________ **Sex:** ☐ M ☐ F **Grade:** ________ **Teacher:** ______________

Parent Guardian : __________________________ **Phone:** _____________

Please check any health concerns your child has. If your child does not have any health concerns, simply check the box, sign and return this form to your child's school. OC ☐ No health concerns at this time (please sign form) OB ☐ **Health condition is life threatening**

Congenital Conditions

A_ ☐ Please list: ________________________________

Hematology (Blood)

BB ☐ **Hemophilia** ______________________________

BC ☐ Sickle Cell Anemia ________________________

BD ☐ Other Blood Condition _____________________

Cardiovascular Conditions

C_ ☐ Please list: ________________________________

Endocrine, Allergy, Immune System, Metabolic, and Nutritional

ED ☐ Allergy – Food ___________________________

EE ☐ Allergy – Insect___________________________

E_ ☐ Allergy – Other ___________________________

EG ☐ **Severe or Anaphylactic Condition**

EJ ☐ Cystic Fibrosis

EK/L ☐ **Diabetes Type I** ☐ Diabetes Type II

EN ☐ Eating Disorder ___________________________

EU ☐ Thyroid Disorder

E_ ☐ Other ___________________________________

Gastro-Intestinal, Dental and Oral Conditions

GA/J/K ☐ Celiac Disease ☐ Crohns ☐ Irritable Bowel

GH/L ☐ Gastroesophageal Reflux ☐ Lactose Intolerance

GI ☐ Other ___________________________________

GM ☐ Liver Disease

GD ☐ Dental Condition __________________________

GN ☐ Oral Condition ___________________________

Musculoskeletal and Connective Tissue

MC ☐ Juvenile Rheumatoid Arthritis

MD ☐ Muscular Dystrophy

MF ☐ Osgood Schlatter

MH ☐ Scoliosis

M_ ☐ Other ___________________________________

Nervous System

NA/C ☐ Asperger's Syndrome ☐ Autism

NB ☐ ADHD/ADD diagnosed by: _________________

NE ☐ Cerebral Palsy

NF ☐ Developmental Delay

NH/I/J ☐ Migraines ☐ Headaches ☐ Shunt

NL ☐ Mental Retardation

NN ☐ Paralysis

NP ☐ **Seizure Disorder**

NQ ☐ Sensory Condition

NS ☐ Spina Bifida

NT ☐ Spinal Cord Injury

NU ☐ Traumatic Brain Injury

Mental or Behavioral Health Condition

PH ☐ Sleep Disorder

PI ☐ Tourette's Syndrome

P_ ☐ Other _________________________________

Respiratory

RA ☐ **Asthma** – Exercise Induced

RB/C/D ☐ **Asthma** ☐ Mild ☐ Moderate ☐ Severe ☐ Inhaler

RE ☐ Reactive Airway Disease

Skin and Subcutaneous Tissue

SB ☐ Contact Dermatitis (Eczema)

S_ ☐ Other ___________________________________

Neoplasms (Cancer/Tumors)

☐ Please list: _______________________________

Renal and Genitourinary

UB/U ☐ Chronic Urinary Tract Infection ☐ Urinary Reflux

UC ☐ Dysmenorrhea (painful periods)

U_ ☐ Other ___________________________________

Eye and Ear

YA ☐ Chronic Ear Infections ____________________

YB ☐ Hearing Impaired _________________________

YC ☐ Ear Condition____________________________

YD ☐ Visually Impaired ________________________

YE ☐ Eye Condition ___________________________

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Hospital Preference: _____________________________

Health Insurance: ☐ No ☐ Yes

Name of Company: _______________________________

Dental Insurance: ☐ No ☐ Yes

Name of Company: _______________________________

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Family Doctor: ___________________________________ Phone: ________________ Date of last exam: ________________

Specialist : ______________________________________ Phone: ________________ Date of last exam: ________________

Dentist: ____ Phone: ________________ Date of last exam: ________________

Is Medication needed at home? ☐ **No** ☐ **Yes** **please list:** ____

Is Medication needed at school? ☐ **No** ☐ **Yes** **please list:** ____

State law requires written permission from parent and or health care provider before any medications, prescription or over the counter, may be taken at school. Forms are available from the school health rooms or school office.

If parent/guardian or authorized emergency contact cannot be reached at the time of a medical emergency, and if immediate care is urgent in the judgment of school authorities. I authorize and direct the school authorities to send the student to the hospital or doctor most accessible. I understand that I will assume full responsibility for the payment of any services rendered. I understand that the information given above will be shared with appropriate school staff who need to know in order to provide for the health and safety of my student.

Date: ____________ **Signature:** _________________________ **Relationship:** ________________ **Phone:** _(___)_________________