Annual Student Health Registration Form

Legal Last Name: First Name:

Please contact your school nurse if your child has any health concerns that need to be addressed in the school setting.
IF YOUR CHILD HAS SPECIAL HEALTH NEEDS AT SCHOOL, WE MUST HAVE WRITTEN DOCTOR'S ORDERS FOR ANY SCHOOL ACCOMODATIONS.

Medical History

*Is your child **currently** being treated for any of the following? Please check all that apply.*

____ Asthma ____Seizure Disorder ____Bladder Disorder ____ADD/ADHD
____Diabetes ____Skin Condition ____Bowel Disorder ____Headaches
____Heart Condition ____Mental health condition (i.e., depression, anxiety, eating disorder) Other_____

Medical Doctor: _____ Phone #: _____
Dentist: _____ Phone #: _____

Allergies

Is your child allergic to any of the following? Please check all that apply.

____Food (list what types of food) _____
____Medicine (list what types of medicine) _____
____Other _____
Describe what happens when your child has an allergic reaction: _____
Does your child need an Epi-Pen at school? ____Yes ____No (If yes, the parent is required to supply school with an Epi-Pen)

Hearing/Vision

Do you have concerns about your child's hearing? ____Yes ____No Does your child wear hearing aides? ____Yes ____No
Do you have concerns about your child's vision? ____Yes ____No Does your child wear glasses or contacts? ____Yes ____No

Medication *Please list all of your child's medications.*

Name of Medication	Time medication is given	Reason for medication

Over-the-counter Medication

Do you want your child to receive an occasional over-the-counter medication at school? ____ **Yes** ____ **No**
If yes, please give permission for the following medication/s: _____**Acetaminophen (Tylenol)** ____**Tums**
____**Ibuprofen (Advil, Motrin)** _____**Antibiotic Ointment** _____**Midol** _____**Anti itch cream** ____ **Cough drops**
_____ **eye drops as needed** _____ **Benadryl (Used only if your child has an allergic reaction at school)**

FOR Kindergarten & 9TH GRADERS: Iowa Law requires all kindergarten & 9th graders to have a dental screening performed by a dentist/hygienist within the last year. Appropriate forms are available on the school website or from elementary and high school offices.

If your child does not return the completed form by the state audit date, do you give permission for a registered Dental Hygienist to examine your child's teeth at school? _____Yes _____No

In Case of Emergency

Please list the names and telephone numbers of people, other than parents, who can be called in case of illness or emergency. They will be called only if parents can not be reached.

Contact #1: Name_____ Contact Number_____ Relationship_____
Contact #2: Name_____ Contact Number_____ Relationship_____
Contact # 3: Name_____ Contact Number_____ Relationship_____

Emergency Release

I give permission to the appropriate personnel of the Lamoni Community School District to secure and authorize emergency medical care and treatment for my child that in their judgment is necessary in the best interest of my child while under their supervision I understand that this health information sheet is confidential but the information may be shared with other Lamoni Community School personnel as needed.

Parent/Guardian Signature: _____ Date Signed: _____