Leyton Public Schools

Student Health Information

Please provide CURRENT updates of your child's health status OR
_____ My child has no changes in health conditions. (Please read reverse side)
The following information is considered confidential and is for the use of teachers, principal, school nurse/health staff, or other staff who will be in contact with and responsible for your child during the school day.

_____

Student Name | Birthdate | Grade

_____

Signature of Parent/Guardian | Printed name/relationship to student | Date

_____ _____

Home Phone | Work Phone

CHECK ANY OF THESE CONDITIONS WHICH YOUR CHILD HAS:

____Cancer	____Kidney/ Bladder Disease	____Vision Problems	____ADD
____Diabetes	____Convulsions, Seizures	____Hearing Problems	____ADHD
____Heart Disease	____Orthopedic/Bone	____Social/Emotional/Behavioral Issues	
____Autism	____Bowel/Bladder Issues	____In Counseling	

____Asthma Provoked by:_____ Severe ____Yes ____No
If yes, please obtain Asthma/allergy action plan from the school secretary.

____Allergy to _____ Severe ____Yes ____No

Has the above condition been diagnosed by a medical doctor? ____Yes ____No
If yes, what is the doctor's name?_____ Phone # _____
May we obtain this information? ____Yes ____No

If yes, please sign a release of information obtained from the school secretary.

What does your child do to manage his/her condition?

_____

_____

How can the teacher help with this at school?

_____

_____

What symptoms should we report to you?

_____

_____

Takes medication daily at ____ home ____school
Medication is: _____
For:_____
If your child must receive medication while at school, an "authorization for medication" form must be completed and signed by parents or legal guardians of the child. If it is for a prescription medication, your child's doctor must sign the form. (chapter 195-182) You can obtain this form from the school secretary.

Provide any information not included above which you think we should know about your child's physical, mental, or emotional health which might affect school performance or require special consideration, ie. Limitations in activities etc.

_____

_____

SCHOOL HEALTH SCREENING

****

_____ I do **NOT** wish to have my child screened at the school.

By making this selection, the parent or guardian will be responsible for a Physician's screening within the last 6 months. <u>This form is due back to the school office prior to admission.</u>
The following information is required:

Height_____ Weight_____ Hearing Screening_____ Distance Vision_____ Dental_____

Physician's Signature_____ Date_____

Student Name_____ Grade_____

Parent/Guardian Signature_____ Date_____