



Health & Allergy Form

Student's name: _____ DOB: _____ Grade: _____

Please check any or all that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> ADHS/ADD | <input type="checkbox"/> Speech difficulties | <input type="checkbox"/> ELL (English Language Learner) |
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Vision (wears glasses) | <input type="checkbox"/> Hearing difficulties |
| <input type="checkbox"/> Weight problems | <input type="checkbox"/> Poor eating habits | <input type="checkbox"/> Diet or Nutritional problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Frequent colds/sore throat |
| <input type="checkbox"/> Physical handicap | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Heart condition |

Further explanation of above items: _____

If your child requires medication at school, an *INSTRUCTIONS FOR ADMINSTRATING MEDICATION* form must be completed.

Asthma (Please provide an Inhaler & complete Medication Administration Form)

Allergies (Please provide an EPI pen & complete Medication Administration Form)

- | | | | |
|------------------------------------|------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Nuts | <input type="checkbox"/> Latex | <input type="checkbox"/> Eggs | <input type="checkbox"/> Strawberries |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Bee Sting | <input type="checkbox"/> other: _____ | |

Are activities restricted? Yes / No If yes, explain: _____

Medications taken/given at home (please list name and dosage of any medication(s) your child is taking:

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Currently under a physician's care? Yes / No Doctor: _____

For what reason: _____

Parental authorization:

I hereby give my consent to LVA to receive from or send to Dr. _____/Health Care Provider any information concerning my child.

Guardian's signature: _____ Date: _____

SCHOOL USE ONLY

Received by: _____ Date received: _____