Lake Mills Area School District – Health Information.

Health Information: This information must be reviewed/updated annually to ensure our records are current.

Student Name:		DOB:	GRADE:

YES (X)	NO (X)		
		Diagnosed Food Allergies: Food Sensitive:	Cause/reaction:
		Other diagnosed allergies:	Cause/reaction:
		Severe reaction to insect stings.	Cause/reaction:
		*EPI-PEN required for the following:	***EPI-PEN at School**: ☐ In School Office ☐ With Student
		*Asthma (check one): ☐ Mild ☐ Moderate ☐ Severe	***Inhaler at School:** ☐ In School Office ☐ With Student
		Heart Condition (describe):	
		Vision Problems (describe):	Wears corrective lens: ☐ Yes ☐ No
		Diagnosed Attention Disorders (describe):	
		Hearing Loss (describe):	
		Diabetes (describe):	
		Seizures (describe):	Date of last seizure:
		Migraines/Headaches (describe):	
		Bathroom Issues (describe):	
		Emotional Problems (describe):	
		Will the student need medication administered at school? ***List Medications:**	***Location of medication**: ☐ With Student (see policy) ☐ In School office

*Students who require medication(s) during school hours must have a current <u>MEDICATION AND/OR EPI-EPI FORM</u> on file. Please note that prescription medication requires a physician's signature as well as a parent/guardians. This form must be submitted to the office prior to medication being administered or taken at school. Medication must come in the original container and match physician/manufacturer directions. Forms can be found on the district website or in any school office.

Additional Pertinent Medical Information:

Please list any medications taken at home that the school needs to be aware of:

The parent/guardian signature below:
- Allows the school to share health concern information with district staff that may come in contact with the student.
- Authorizes that information regarding treatment or injury may be shared between emergency personnel and the appropriate district staff.
- Authorizes treatment by trained district staff for my child in the case of injury or medical treatment.

Signature: **Date:**