Le Sueur-Henderson Public Schools ■ ISD 2397
Annual Health/Emergency Information 2023-2024 PreK - 5th grade

Student Name ________________________________ Date of Birth ___________ Grade _____

EMERGENCY CONTACT INFORMATION

Parent/Guardian Name ____

Phone (H) ____________________ (W) ____________________ (Cell) __________________

Parent/Guardian Name ____

Phone (H) ____________________ (W) ____________________ (Cell) __________________

If a parent/guardian cannot be reached, please call:

Name _________________________ Relationship ________________ Phone ______________

Name _________________________ Relationship ________________ Phone ______________

Family Physician/Health Care Provider ___________________________ Phone _____________

Family Dentist ____ Phone ______________

HEALTH CONCERNS

Does your child have a medical condition that school should be aware of? Yes _____ No _____

If yes, please describe:

Asthma __________________________ Physical Disability __________________________

Diabetes _________________________ Hearing/Vision ______________________________

Seizure Disorder ___________________ ADD/ADHD _________________________________

Heart Condition ____________________ Mental Health _____________________________

Bladder/Bowel ______________________ Concussions ______________________________

Dietary Restrictions _________________ Frequent Headaches _________________________

Other ____________________________

Does your child have a medically diagnosed, life-threatening allergy? Yes ______ No _______

Allergies/reaction ____

Requires Epi-Pen? Yes _____ No _____

In the past year, has your child had any major illness, operation or injury? Yes _____ No _____

Specify: ____

Is your child taking Medication? Yes ______ No ______ If yes, please list medication and dose:

____

____

Reminder: ISD 2397 requires a "Consent form for Administration of Medication During the School Day" form signed by a licensed healthcare provider and parent before prescription or over the counter medication (including insulin, inhalers, Epi-Pen) may be taken at school. Please refer to the school district medication guidelines.

Please complete side 2

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Is there a condition that may limit your child's participation in:

- Classroom Activity? Yes ______ No ______ If Yes, ____________________________________
- Physical Education? Yes ______ No ______ If Yes, ____________________________________

Do you have other concerns about your child's physical health or emotional well-being?

Please specify ____

____

- The information provided on this form will be shared in a confidential manner with appropriate staff members or emergency personnel who need to know, in order to provide for the safety and health needs of the student.
- For the safety of your student, you must keep the school informed of any changes in health status or contact information.
- ISD 2397 may take whatever emergency measures are judged necessary for the safety of the student. In case of a medical emergency, a student may be transported to the local medical center. Any charges incurred are the responsibility of the parent/guardian. In some situations, school staff may need to contact local emergency resources before a parent or other emergency contact can be notified.
- If the student rides the school bus, it is the responsibility of the parent/guardian to inform the bus company of the student's health condition and plan.
- If the student participates in before/after school activities, it is the responsibility of the parent/guardian to inform the coach/supervisor of the student's health condition and plan.

NEW

Over-the-counter medication will be available for students in the health office with parent/guardian permission. **Students are not allowed to carry over-the-counter medications in school. Only emergency medications can be carried with a healthcare provider order.** (Epi-Pen, inhaler, insulin)

**Please indicate which medication you are giving consent for your child to receive while at school.

**Dose will be based on weight.

Tylenol chewable **(160mg/tablet)**: _______ **Ibuprofen** chewable **(100mg/tablet)**: ______

Pepto Kids chewable: ________ **Benadryl** chewable **(12.5mg/tablet)**: _______

Parent/Guardian Authorization:

1. I request that the above medication be given to my child during regular school hours (no after school activities).
2. I give permission for the medication to be given by the designated personnel as delegated, trained, and supervised by the Licensed School Nurse.
3. I authorize the Licensed School Nurse/designee to exchange information with my child's healthcare provider concerning any questions that arise with regard to the listed medication, medical condition, or side effects of this medication.

3. I release school personnel from the liability in relation to the administration of this medication at school.

* ____ ______________________

Parent/Guardian Signature Date

Reminder: If your child becomes ill at school, school procedure indicates that he/she must go to the health office for assessment prior to being excused. The school nurse or health office representative will call the parent/guardian as necessary. A call to a parent by the student without following this procedure will be considered an unexcused absence.

(05/2023)