Little Rock School District Health Services Form

Student's Printed Name: Birthday: Grade:

Health Diagnosis
Check all that apply (include date diagnosed)

- ADHD/ADD ☐
- ASTHMA- (Asthma Action Plan required) ☐
- DIABETES ☐
- HEART DISEASE ☐
- KIDNEY DISEASE ☐
- SEIZURES ☐

Date of most recent SEIZURE:

Past Surgeries & Dates:

Other Diagnosis:

Allergies (list allergies for each category)

Circle here if no known allergies: NKA

Seasonal Allergies:

Food Allergies: *Dietary form must be filled out by the physician (Dietary form available in school office)*

Epi-Pen Provided Circle one YES NO

Drug Allergies:

Other Allergies:

Behavioral / Mental / Emotional Concerns
Include date diagnosed

Diagnosis:

Physician:

Therapists:

Medications

All medication must be given at home unless it is given more than 3 times per day or at a specific time as indicated on a prescription bottle. No Over the Counter meds will be given.

Home medication, dosage, and date started

1.

2.

3.

School medication, dosage, and date started

Consent form available in office.

1.

2.

3.

Potential side effects:

Health Procedures or Special Services required.

IMPORTANT: Doctor must fill out Individual Health Plan form (form available in office) & procedures must be in place before student's first day of school.

List Procedures:

Insurance / Health Provider Information

ARKids: *Medicaid:* yes / no
If yes show #

Private Insurance yes / no
If yes, insurance name:

Check here if "No Health Insurance": ☐

Dentist:

Doctor(s):

Hospital Preference:

Parents Consent

I give consent for emergency medical treatment. I understand that I will be responsible for payment of any and all medical care services, including but not limited to emergency care that is not covered by the student's health insurance. I give consent for this information to be shared with my child's teacher and appropriate school staff and I certify all information given is correct.

Parents Signature:

x

Date:

SCHOOL COPY