Health Services use only:
Reviewed/ Entered by: _____
Parent Contacted: _____
Orders on file: _____

Waddell Elementary School
2024-2025
Student Health History

To be completed by parent/guardian

Name of Student: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

☐ No ☐ Yes Glasses/ Contacts, Date of last eye evaluation: _____

☐ No ☐ Yes Hearing aids Date of last hearing exam: _____

Primary Doctor: _____ Dentist: _____ Date of last dental visit: _____

Insurance Carrier: _____ Identification Number: _____

Daily Medications

Lexington City Schools requires written permission from a Health Care Provider and parent before any medication **(prescription or over-the-counter)** can be given at school. A form is available at your school office. **Prescription medication** must be provided in the original, pharmacy- labeled container. The information on the label and authorization form must match. **Over-the-counter medication** must be provided in the original, unopened, sealed container with the manufacturer's label and the child's name. The parent/guardian must label the container with his/her child's name without covering the manufacturer's label.

Life Threatening Conditions (Requires Health Care Provider Orders)

Please check all that apply and list medication needed:

☐ No ☐ Yes Severe Allergic reaction to Nuts (list): _____

☐ No ☐ Yes Severe Allergic reaction to Bee Stings requiring emergency medication: _____

☐ No ☐ Yes Other Severe Allergies- affecting school. Specify: _____

☐ No ☐ Yes Severe Asthma: regularly takes medication for asthmatic condition and/or hospitalized within the last 5 years for asthmatic condition: _____

☐ No ☐ Yes Diabetes: _____

☐ No ☐ Yes Seizure Disorder that requires an emergency medication: _____

Health Concerns (Potentially life threatening conditions that may require Health Care Providers orders)

☐ No ☐ Yes Asthma: takes medication only when needed: _____

☐ No ☐ Yes Seizure: Type of seizure and date of last seizure: _____

☐ No ☐ Yes Heart Condition: _____

☐ No ☐ Yes Behavioral/Emotional Concerns: _____

☐ No ☐ Yes Other Health Concerns: _____

☐ No ☐ Yes Any Chronic or recurring illness: _____

Does your child have any other condition that would affect his/her classroom performance or P.E. activities?

☐ No ☐ Yes If yes, explain: _____

All health information is considered confidential. It may be shared with staff as needed during the time your child is enrolled in Lexington City Schools in order to ensure the health and safety of your child, unless otherwise requested by you in writing.

Parent/ Guardian Signature _____ Date _____