Lexington Public Schools

STUDENT HEALTH HISTORY: To be completed by parent or guardian at time of enrollment

Name of Student: _____ Grade _____ Male/Female (circle one) Date of Birth _____

	Yes	No		Yes	No
ADD/ADHD-Diagnosed by MD			Diabetes Type I or II		
Allergies to food or insects			Has Epi Pen for allergic reactions/must have a form from MD signed		
Bleeding Disorders			Hearing or Speech problems		
Anxiety/Depression			Heart Condition		
Asthma-uses an inhaler/must have a form from MD signed			Seizures		
Bladder/Bowel Problems			Stomach Problems		
Cancer			Tuberculosis		
Cystic Fibrosis			Vision issues: wears or has glasses/contacts		
Dental Problems			Other Issues		

If you answered YES to any of the above, especially allergies, please tell us more:

_____

_____

What medications does your child take at school? _____

Students requiring any over-the-counter (OTC) medications at school MUST have a current school year Medication Request and Release on file. Physician authorization is required for any prescription medication to be given at school. Please contact the school for medication consent forms.

Name of Child's Physician: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____

Emergency phone numbers: Home: _____ Cell: _____ Work: _____