

**Lutheran Central School  
HEALTH HISTORY UPDATE**

Student Name \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Physician \_\_\_\_\_ Physician's phone # \_\_\_\_\_

**ALLERGIES:**

List ALL ALLERGIES (medication, environmental, foods, insects, latex)

REACTION that occurs if exposure occurs (rash, itching, swelling, hives, anaphylactic)

CARE necessary if reaction occurs at school (ice, benadryl, epinephrine)

**MEDICATIONS:**

List all medications taken daily (include those that will not be administered at school)

**MEDICAL CONDITIONS:**

Please indicate by circling if your child has been diagnosed by a physician with any of the following conditions:

ASTHMA

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

BLEEDING CONDITION

BROKEN BONES List: \_\_\_\_\_

DIABETES MELLITUS

HEART CONDITION

HYPERTENSION (high blood pressure)

SEIZURE DISORDER

SKIN PROBLEMS (itching, rashes, acne)

CONTACT LENSES / GLASSES

USE OF ANY SPECIAL EQUIPMENT List: \_\_\_\_\_

**HISTORY:**

LIST PAST HOSPITALIZATIONS or SURGICAL PROCEDURES \_\_\_\_\_

HAVE YOU EVER HAD ANY MEDICAL CONDITIONS (such as: mononucleosis, anemia, etc. Please list) \_\_\_\_\_

DATE OF LAST TETNUS SHOT \_\_\_\_\_

**OTHER:**

LIST ANY OTHER HEALTH CONCERNS YOU HAVE FOR YOUR CHILD THAT YOU FEEL WE SHOULD KNOW: \_\_\_\_\_

I understand that it is my responsibility to notify the School Nurse of any medical changes in my child's health. I also understand that unless I request to update my child's health history information that this is the form that will remain on file throughout this school year. I understand that if my child has a medical condition or allergy indicated above that it would be necessary for me to provide updated information (such as an Asthma Action Plan, Diabetic Plan, Seizure emergency plan, etc.). I understand that this is confidential information and will only be shared with school staff members that work directly with my child to understand my child's health care needs at school and school sponsored events. I understand that in the event of reasonable unsuccessful attempts to contact my child's emergency contacts, I hereby give my consent for the administration of any emergency treatment deemed necessary. I also consent to release any additional necessary medical information to Joyce McKinney RN, School Nurse and / or Melissa Luedeman LPN Assistant School Nurse.

Signature of Parent/ Guardian \_\_\_\_\_ Date \_\_\_\_\_