Central Lyon Student Health Registration • School Year: _____

Student's Name: _____ **Date of Birth:** _____ **Grade:** ____ **Gender:**___

When child is ill or injured, please list which parent/guardian the school should notify first. Please list in preferred order of contact.

#1) Name: _____ Relationship: _____ Cell#:_____ Work#:_____

#2) Name: _____ Relationship: _____ Cell#:_____ Work#:_____

In case parent can't be reached, please contact the individual below: This person has agreed to assume this responsibility and is local.

#3) Name: _____ Relationship: _____ Cell#:_____ Work#:_____

HEALTH CONCERNS *Mark the box* ☒ *if your child has a history of the following conditions. Mark additional information as needed.* ***Additional forms may need to be completed by your physician (marked with ***).*** *Forms available on school website.*

☐ **Asthma or Reactive Airway Disease**
- ▪Triggers→ ☐Exercise ☐Colds/Allergies ☐Animals ☐Smoke ☐Weather ☐Food ☐Dust/Air ☐ Other: _____
- ▪Will the inhaler ever be needed at school? ☐ No ☐ Yes → **Asthma Action Plan*****
- ▪Will the student carry their own inhaler? ☐ No ☐ Yes → **Authorization to Carry/Self-Administer*****

☐ **Diabetes** ☐Type 1 ☐Type 2
- ▪Does the student use insulin? ☐ No ☐ Yes → **Diabetic Medical Management Plan*****
- ▪Does the student have glucagon? ☐ No ☐ Yes → ☐At school → ☐Office ☐Backpack ☐Locker #_____

☐ **Seizure Disorder → Seizure Action Plan*****
- ▪Does the student have rescue meds? ☐ No ☐ Yes → ☐At school → ☐Office ☐Backpack ☐Locker #_____

☐ **Allergies** [Food, Insect, Seasonal, Medication]
- ▪Is the student at risk for anaphylaxis at school? ☐ No ☐ Yes → **Allergy & Anaphylaxis Emergency Plan*****
- ▪Will the student need a lunch accommodation? ☐ No ☐ Yes → **Diet Modification Form*****
- ▪Does the student have an EpiPen? ☐ No ☐ Yes → ☐At school → ☐Office ☐Backpack ☐Locker #_____
- ▪List allergies below:

☐Food(s)→ ☐Peanut ☐Tree Nut ☐Eggs ☐Milk ☐Fish/shellfish ☐Soybean ☐Gluten ☐Other:_____

☐Insect stings ☐Seasonal allergies ☐Medication(s): _____ ☐Other:_____

☐ **Other medical history or current medical/developmental concerns** that could affect child's education (*use back if necessary*): _____

☐ Heart Condition/Murmur/Disease/Surgery: _____

☐ History of Concussion / Head Injury: _____

☐ Headaches / Migraines: _____

☐ Bowel/Bladder Concerns or Incontinence: _____

☐ Activity Restrictions (ongoing) → **Doctor's note required for explanation****:_____

☐ ADD / ADHD ☐ Emotional and/or Behavioral Diagnoses → ☐Anxiety ☐Depression ☐Other:_____

☐ Requires medication (list in chart below)

MEDICATIONS *List ALL medications taken regularly at home or at school. Please specify frequency and reason for use. Use back if necessary.*

Medication:	Dose:	Time(s) Taken:	Frequency:	School / Home	Reason for use:

☐ ***I give permission*** *to the school to administer over-the-counter medications (such as but not limited to acetaminophen, ibuprofen, antibiotic ointment or cough drops) to my child if supply is available. Medication will only be given per label indication and dosed according to age.*

☐ ***I do <u>NOT</u> give permission*** *to the school to administer any medications the school has available.*

I understand that any medication sent from home to be taken at school needs to be in the original labeled container and a Medication Authorization Form must be completed in order for it to be given. I understand that students may not carry any medications. I give permission to the school to contact my child's doctor/dentist to confirm appointments and authorize medications/plans of care as necessary. If an emergency should arise, I agree to assume full financial responsibility for my child's medical care. I understand it is my responsibility to update any of the above information as needed. I understand this information is confidential but may be shared with appropriate school personnel when necessary for the child's safety or education.

Parent/Guardian Signature:_____ **Date**: _____