

# LACORDAIRE ACADEMY

## ANNUAL STUDENT HEALTH HISTORY UPDATE

Name:	DOB:	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian: (person completing this form)	Grade:	Home Phone:	Date:
		Cell Phone:	

In the past 12 months, has your child:	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition	<input type="checkbox"/>	<input type="checkbox"/>	
Seen a medical specialist	<input type="checkbox"/>	<input type="checkbox"/>	
Had allergies: <input type="checkbox"/> food <input type="checkbox"/> environmental <input type="checkbox"/> insect <input type="checkbox"/> medication <input type="checkbox"/> other	<input type="checkbox"/>	<input type="checkbox"/>	
Been hospitalized	<input type="checkbox"/>	<input type="checkbox"/>	
Had an operation	<input type="checkbox"/>	<input type="checkbox"/>	
Had an injury requiring an Emergency Room visit	<input type="checkbox"/>	<input type="checkbox"/>	
Missed 5 days of school in a row due to illness/injury	<input type="checkbox"/>	<input type="checkbox"/>	
Had a bone/muscle injury	<input type="checkbox"/>	<input type="checkbox"/>	
Passed out, had a concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	
Had a convulsion/seizure	<input type="checkbox"/>	<input type="checkbox"/>	
Had a vision problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> glasses <input type="checkbox"/> contacts
Had a hearing problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> hearing aid <input type="checkbox"/> cochlear implant
Worn dental bridge, braces or mouthpiece	<input type="checkbox"/>	<input type="checkbox"/>	
Have any family members under the age of 50 ever:	YES	NO	If Yes, please specify:
Had a heart attack	<input type="checkbox"/>	<input type="checkbox"/>	
Had other serious health problems	<input type="checkbox"/>	<input type="checkbox"/>	

**CHECK ALL THAT APPLY TO YOUR CHILD:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> ADHD/ADD<br><input type="checkbox"/> Asthma/trouble breathing<br><input type="checkbox"/> Autism/Asperger<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Dental Injuries<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Ear Infections<br><input type="checkbox"/> Epilepsy/Seizures<br><input type="checkbox"/> GI Conditions (ulcer, reflux, IBS) | <input type="checkbox"/> Headaches/migraines<br><input type="checkbox"/> Heart Conditions<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Mental Health Condition:<br>(Depression, eating disorder, anxiety, OCD,<br>ODD, etc.)<br><input type="checkbox"/> Scoliosis<br><input type="checkbox"/> Single Organ ( <input type="checkbox"/> kidney, <input type="checkbox"/> testicle) | <input type="checkbox"/> Skin Condition<br><input type="checkbox"/> Speech Condition<br><input type="checkbox"/> Urinary Condition<br><input type="checkbox"/> Coronavirus (COVID-19) Diagnosis<br><input type="checkbox"/> If yes, symptomatic or hospitalized?<br><input type="checkbox"/> Any household member diagnosed<br>with Coronavirus (COVID-19)? |
|--|--|---|

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	<input type="checkbox"/>	<input type="checkbox"/>	
Taken at home	<input type="checkbox"/>	<input type="checkbox"/>	
TREATMENTS	YES	NO	
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> insulin/blood glucose monitoring <input type="checkbox"/> inhaler/nebulizer/peak flow monitoring <input type="checkbox"/> special diet

Is there any condition that would prevent your child from participating in physical education or sports?

No     Yes: \_\_\_\_\_

Please list any additional concerns: (use back of sheet if necessary) \_\_\_\_\_

To ensure the care of my child, I agree that pertinent health information may be shared with appropriate school staff, and may be forwarded to emergency medical personnel in emergency situations. I agree to notify the school nurse of any changes in medication, dosage, or change in any health status of my child. I agree if any of the above information changes, I will notify the school immediately. I understand that in case of an emergency the school will first attempt to contact me. If I cannot be reached, I authorize the transport of my child to a hospital and authorize any physician or medical personnel to carry out any diagnostic procedures or emergency care deemed necessary. I will accept full financial responsibility for charges connected with the use of an ambulance and charges connected with any medical care necessary. I acknowledge that all foregoing above information is true and correct.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_