Lake Central School Corporation
Health Services
Health Form

Student's Full Name: ___________________________________ Date: _____________
New or **Returning** Student (Circle one) Grade: _________ Student's Date of Birth: ________

Does the student have any of the following health conditions?

Health Conditions			**Comments:** Include all dates, symptoms and treatment as they apply
ADD/ADHD *	**Yes**	**No**	
Allergies(food,medication, insects, etc.) *	**Yes**	**No**	
Asthma *	**Yes**	**No**	
Cancer(Type)*	**Yes**	**No**	
Diabetes(type 1 or 2) *	**Yes**	**No**	
Heart Problems*	**Yes**	**No**	
Head Injury/Concussion	**Yes**	**No**	
Kidney/Urinary Problems	**Yes**	**No**	
Eye/Vision Problems*	**Yes**	**No**	
Hearing Problems*	**Yes**	**No**	
Neurological Problems/Seizures*	**Yes**	**No**	
Bleeding Disorders*	**Yes**	**No**	
Autism	**Yes**	**No**	
Physical Handicaps	**Yes**	**No**	
Other Health Issues	**Yes**	**No**	

***Additional Form Required - Physician's Order Required**

Does the student take any medication on a regular basis? **Yes** (list below) **No**

Medication	Dose	Time	Reason for Giving	Taken at School
				Yes/No
				Yes/No
				Yes/No
				Yes/No

Note: If your child will be taking medication at school, whether prescription or over-counter, please complete the school medication form.

Does your child have any restrictions at school: **Yes_____** **No** _____ (If so, Physician's note is required)

I understand that I may be required to furnish a doctor's statement verifying the above information. I also understand that this information is confidential and is being furnished for the exclusive use of the Lake Central School Corporation Health Services and will not be released to any non- school personal without my written consent.

Parent/Guardian Signature: ____