



Lindbergh Schools

4900 S. Lindbergh Blvd., St. Louis, MO 63126 • 314-729-2400 • www.lindberghschools.ws

ANNUAL STUDENT HEALTH INFORMATION FORM

Student Name _____ Date of Birth _____ Grade _____

Parent(s) Name _____ Phone _____

Alternative Contact Name _____ Phone _____

Doctor's Name _____ Phone _____

Specialist's Name _____ Phone _____

HISTORY / MEDICAL DIAGNOSES-Please check any that apply

Asthma Diabetes ADHD Autism Seizure Disorder Heart/Lung

| | | | |
|----------------|----------------|----------------------|-----------------|
| Drug Allergies | Food Allergies | Insect/Bee Allergies | Other Allergies |
| | | | |

Other Health Concerns/ Comments/Nursing Care Requested at School

List Prescription Medication(s) Given at Home or School _____

Medical diagnoses that impact your child's health and safety during the school day and/or require treatment or accommodations, such as severe food allergies, asthma, etc... will need an Action Plan completed by the physician and medication provided to your school nurse.

NOTICE OF AGREEMENT

To ensure safe care of my child, I agree that pertinent health information may be shared with appropriate school staff on a need to know basis. I agree to alert the school nurse of any change in medication or health status of my child. I will furnish the school with current phone numbers and address in case of emergency.

Each school building is stocked with injectable Epinephrine (Epi-Pen) and staff members are trained annually in case of anaphylaxis. I understand that basic first aid and emergency care will be provided as needed by school staff.

I understand that in an emergency my child will be transported by ambulance. I authorize emergency personnel to carry out diagnostic and emergency care as deemed necessary. I understand the cost of ambulance and medical care are my responsibility.

I acknowledge that the foregoing above information is true and correct.

Signature of Parent _____ Date _____