Liberty Public Schools Health Record Update 2020-21

(Through Summer School)

Student:_____ Birth Date:_____ Sex: M / F
(Last) (First) (MI)

Grade:_____ Teacher:_____

Does the student have a family doctor? Yes ___ No ___

Name of doctor or practice: _____ Phone Number:_____

Does your child take any medication on a regular or daily basis? Yes ___ No ___
Please list all medications, dosages, and times given:

_____

_____

Note: If a student is to receive other medication at school, a separate *Medication Authorization* form (https://www.lps53.org/Page/1981) will need to be completed. Medications will be supplied by the parent.

Medical History: Please indicate if your child has any of the following conditions:

Asthma Yes ___ No ___ Type of inhaler _____
(If marked "yes", please answer further asthma questions.)

Will your child need to use the inhaler before PE and/or recess daily? Yes___ No ___
Exercise induced Yes ___ No ___
Mild, no inhaler used Yes ___ No ___
Moderate, child has inhaler Yes ___ No ___
Severe, child regularly uses inhaler Yes ___ No ___

Allergies Yes ___ No ___
(Do not list food intolerances here – only diagnosed allergies)

If yes, please describe food allergy details _____

Allergic to bee or insect stings Yes ___ No ___

Allergies to medication/drug Yes ___ No ___

If yes, please describe/list _____

Other allergies Yes ___ No ___ Please describe _____

Child has epinephrine (Epi-pen) Yes ___ No ___ Takes antihistamine related to severe allergies Yes ___ No ___

Diabetes Yes ___ No ___
(If yes, please answer further questions)
Need snacks at school Yes ___ No ___
Takes insulin Yes ___ No ___
Type and time given _____

Seizure disorder Yes ___ No ___

Type of seizures _____

Cardiac (heart) condition Yes ___ No ___

If yes, please explain _____

Respiratory Impairment Yes ___ No ___ If yes, please explain

_____

Cerebral palsy	Yes ___ No ___	**Kidney disease**	Yes ___ No ___
Cystic Fibrosis	Yes ___ No ___	**Neurological disorder**	Yes ___ No ___
Arthritis	Yes ___ No ___	**Scoliosis**	Yes ___ No ___
Bone/joint disorder	Yes ___ No ___	**Cancer**	Yes ___ No ___
Hemophilia/blood disorder	Yes ___ No ___	**Migraines/headaches**	Yes ___ No ___
Skin Disorder	Yes ___ No ___	**Muscular Dystrophy**	Yes ___ No ___
Low blood sugar	Yes ___ No ___	**Stomach disorder**	Yes ___ No ___
Eating disorder	Yes ___ No ___	**Hyperactivity (ADHD)**	Yes ___ No ___
Attention deficit disorder(ADD)	Yes ___ No ___	**Bipolar Disorder**	Yes ___ No ___
Anxiety	Yes ___ No ___	**Depression**	Yes ___ No ___
Autism	Yes ___ No ___	**Asperger's**	Yes ___ No ___
Cleft palate	Yes ___ No ___	**Recurrent ear infections**	Yes ___ No ___
Tongue Tied (Ankyloglossia)	Yes ___ No ___	**Wears glasses or contacts**	Yes ___ No ___
Hearing difficulty	Yes ___ No ___	Affected ear: Right ___ Left ___ Both ___	
Hearing aid(s)	Yes ___ No ___	Which ear(s): Right ___ Left ___ Both ___	
Other Psychiatric disorder	Yes ___ No ___	Please List _____	

Additional details from conditions above or other conditions, illnesses, or surgeries not listed _____

_____

_____

Food Intolerances Yes ___ No ___

Special diet Yes ___ No ___ Please explain _____

Note: For any diet modifications while at school, the following form is required to be completed by your physician.
https://www.lps53.org/Page/6359
For questions, please contact the Nutrition Services Department at 816-736-5375.

Do you believe your child has a physical or mental impairment that substantially limits a major life activity in the school environment? Yes ___ No ___

If yes, please explain the condition and how it substantially limits your child _____

_____

Does your child currently have a written health accommodation plan Yes ___ No ___

Health History - Download Forms
If you have indicated that your child has asthma, diabetes, life threatening allergies, food allergies, or a seizure disorder, please download and complete additional paperwork found at the following link: https://www.lps53.org/Page/1981 You will need to complete this paperwork and turn it in to the school nurse.

For Students in Grades 6-12 only:
I give permission for my child to take Acetaminophen (Generic Tylenol) 325mg (1-2 tablets) every 4 hours as needed during the school day. *Note: You will be notified if your child has taken 10 doses of Acetaminophen in a school year. We will only give 25 doses of any combination of medications containing Acetaminophen (such as Tylenol) or non-steroidal anti-inflammatory medication such as Ibuprofen, Aleve, etc. in one given school year. A doctor's order will be required for any additional doses above 25. The school only stocks Acetaminophen. Others need to be provided by the parent/guardian.*

Acetaminophen (Generic Tylenol) Yes ___ No ___
By checking *yes*, I give permission for my 6th-12th grade student to take Acetaminophen 325mg (1-2 tablets) every 4 hours as needed.

While medical information is confidential, I understand the school nurse and other school staff may at times deem it necessary to share a student's information, including district health update forms as supplied by the parent with other school personnel, including but not limited to: Teachers, administrators, transportation, cafeteria, and support staff. As a parent I may also share information as I deem appropriate with my child's teacher, bus driver or other specific staff member independent of the school nurse or other school staff sharing this information.

Parent/Guardian Signature _____ **Date**_____