LACROSSE SCHOOL DISTRICT
STUDENT MEDICAL HISTORY FORM

Student Name: _____ Grade: _____

Life Threatening Condition:

Does your child have a life threatening condition (i.e. diabetes, heart condition, asthma, allergic reaction that can result in anaphylactic shock)? No ___ **If Yes please describe:** _____
_____

Medical History

Does your child have a history of: (check all that apply)

___Frequent Headaches	___Fainting Spells	___Frequent Colds
___Hay Fever	___Tubes In Ears	___Hoarseness
___Tires Easily	___Mouth Breather	___Bleeder
___Frequent Stomachaches	___Hearing Problems	___Poor Appetite
___Heart Disease	___Frequent Urination	___Speech Difficulty
___Seizures or Spells	___Dental Problems	___Bone Disease
___Convulsions With High Fever	___Vision Problems	___Chicken Pox
___Skin Problems	___Eczema	___ Pneumonia
___Frequent Nose Bleeds	___Tonsillitis	___ Rheumatic Fever
___Breathing Problems	___Frequent Sore Throat	___ Color Blindness
___Clumsiness	___Other_____	

___Asthma **Regularly takes medication for asthma or has been hospitalized within the last five (5) years for asthma.**
___Diabetes Type 1____ Type II____

Allergies (check all that apply)

___Dust ___Mold ___Pollens ___Cut Grass ___Animals ___Bees ___Other
___Foods *If there is a food allergy, please pick up a "Diet Prescription For Meals At School" form from the office for your physician to complete.*

Is the allergy: Mild_____ Moderate_____
Severe_____ Requires an Epipen_____
Please describe symptoms: _____

Medication

Does your child regularly take medication at home (other than vitamins)? ____Yes ___No
List medications taken at home:_____
Does your child need to take medication at school? ___Yes___No
If yes, an "Authorization For Administration Of Oral Medication At School" form will need to be completed for any prescription or over-the-counter medication to be given at school.

General Health

Does your child have a chronic or medical handicap? ___Yes ___No
Please list any condition your child might have that restricts his/her physical activities at school: _____
Does your child wear glasses? ___No ___Yes
Do you have any concerns about your child or do you wish help in working with any problems your feel your child has?_____

LACROSSE SCHOOL DISTRICT
AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

As legal custodian of _____, a minor, I hereby authorize the principal or the principal's designee, into whose care the aforementioned minor pupil has been entrusted, to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to said minor upon the advise of any licensed physician and/or dentist, provided that reasonable attempts have been made to contact parents/guardians at home and emergency numbers.

I understand that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the aforementioned agent(s). I understand that the LaCrosse School District, its employees and its Board assume no liability of any nature in relationship to the transportation or treatment of the said minor. I further understand that all costs of paramedic transportation, hospitalization, and any examination, x-ray or treatment provided in relation to this authorization shall be my responsibility.

I understand that the LaCrosse School District does not provide accident medical insurance for students for school-related injuries but does offer student accident insurance for voluntary purchase.

PLEASE CHECK: ___I will enroll my child in the optional insurance program.
___I will not enroll my child in the optional insurance program.

Doctor and Dental Information

Doctor's Name_____Phone Number_____

Dentist's Name_____Phone Number_____

Hospital of choice: _____ Whitman Hospital & Medical Center
_____ Pullman Regional Hospital
_____ No preference

Health Insurance

Health Plan.Insurance (i.e. Blue Cross, Group Health) _____

Group/Policy#_____

Address_____Phone#_____

*Parent Signature:*_____ *Date:*_____

Home Phone _____ *Work Phone*_____

Cell Phone _____