Health & Allergy Form

Student's Name: _____ DOB: _____Grade: _____

Please check any or all that apply:

_____ADHS/ADD	_____Speech difficulties	_____ELL (English Language Learner)
_____Seizure	_____Vision (wears glasses)	_____Hearing difficulties
_____Weight problems	_____Poor eating habits	_____Diet or Nutritional problems
_____Diabetes	_____Frequent headaches	_____Frequent colds/sore throat
_____Physical handicap	_____Mental Health	_____Heart condition

Further explanation of above items: _____
_____

If your child requires mediation at school, an *INSTRUCTIONS FOR ADMINISTRATING MEDICATION* form must be completed.

_____Asthma (Please provide an Inhaler & complete Medication Administration Form)
_____Allergies (Please provide an EPI pen & complete Medication Administration Form)

_____Nuts _____Latex _____Eggs _____Strawberries

_____Ibuprofen _____Bee Sting _____ Other: _____

Are activities restricted? Yes / No If yes, explain: _____

Medications taken/given at home (please list name and dosage of any medication(s) your child is taking:

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Currently under a physician's care? Yes / No Doctor: _____

For what reason: _____

Parental authorization:

I hereby give my consent to LVA to receive from or send to Dr. _____ /Health Care Provider any information concerning my child.

Guardian's Signature: _____ Date: _____

SCHOOL USE ONLY

Received by: _____ Date received: _____

Rev. 07/1/2025