**LABBB Health Office at Lexington High School**
251 Waltham St. Lexington, MA 02421
Tel: 781-861-2400 ext 1009
Fax: 781-861-1351

**ANNUAL AND NEW STUDENT HEALTH INTAKE**
**SCHOOL YEAR: _____**

Dear Parent/Guardian:
Thank you for taking the time to fill out this brief health information history on your child as they enter or return to school at LABBB. This information will help the school nurses better understand your child, and assist in the transition to school life. **Please send a copy of all immunizations to the Health Office and please send a copy of your child's most recent physical exam.**

Student Name:_____ Birth date:_____

Primary Care Provider:_____ Phone:_____

Preferred Hospital/Medical Center:_____

Please list student's MEDICAL AND/OR PSYCHIATRIC DIAGNOSIS:

| |
|---|
| |
| |

Please list all student's ALLERGIES (medications, foods, latex, stinging insects):

| |
|---|
| |
| |

Does your child have an EpiPen? ☐ YES ☐ NO

A **life threatening allergy** to food, latex, or stinging insects requires an Allergy Action Health Care Plan be developed and medication orders for an EpiPen be in place before entry to school. If yes, Please contact the LABBB Health Office as soon as possible.

Does your child have a history of seizures? ☐ YES ☐ NO

- If yes, please fill out attached **LABBB SEIZURE PLAN**
- We will accept seizure plans written and signed by licensed prescribers. We may ask for the LABBB plan to be filled out if additional information is required.

**Please note all students with seizures must have a signed seizure plan on file for each school year**

Does your child have asthma? ☐ YES ☐ NO
If yes, does your child require the use of an inhaler? ☐ YES ☐ NO

If an inhaler is needed at school, a medication order from your doctor and an asthma action plan is required before entry.



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Does your child have any other emergency medications (ex: glucagon, oxygen, etc)?:

_____

Does your child have vision loss? ☐ YES ☐ NO
If yes, please describe_____

Does your child have hearing loss? ☐ YES ☐ NO
If yes, please describe_____

Does your child use any devices for walking/movement? ☐ YES ☐ NO
If yes, please describe_____

Date of Last Physical Exam:_____ Please provide documentation.

Please list ALL medications your child takes (to be completed if not in violation of confidentiality):

| Medication Name | Purpose | Time(s) Taken |
|---|---|---|
| | | |
| | | |
| | | |
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| | | |

**A **Medication Order Form** including the **Parent/Guardian Authorization for Medication Administration**, completed by your child's licensed prescriber and a parent/guardian, must be submitted to the school nurse for all prescribed and over the counter medications administered during the school day.**

Please comment on anything else you feel is important for the health office to be aware of:

_____
_____
_____
_____
_____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____Date: _____

Student Signature (if over 18): _____ Date: _____



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