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

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 DIAGNOSES:**

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 Seizure Plan to be filled out if additional information is required.

**** Please note that 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 student's doctor, as well as a completed Asthma Action Plan, is required before entry to school.

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Does your child have any other emergency medications (i.e. 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 examination: _____ 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:

** 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 any additional information that 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: _____