LEXINGTON-FAYETTE COUNTY HEALTH DEPARTMENT (LFCHD)
SCHOOL HEALTH SERVICES DIVISION

650 Newtown Pike
Lexington, Kentucky 40508-1197
(859) 288-2314
(859) 288-2313 FAX

Student Health Information

(Please complete one form per student)

SCHOOL: _____ **SCHOOL YEAR:** _____

Last Name :_____ **First Name :** _____ **MI :** ____

(Please give student's complete legal name.)

Student's Social Security #_____ **Birth Date:** _____

Race: _____ ☐ **Male** ☐ **Female** **Home Room Teacher:** _____

Street Address_____ City_____ Zip _____

Mother _____ Hm Ph _____ Wk Ph _____ Cell Ph _____

Father _____ Hm Ph_____ Wk Ph _____ Cell Ph _____

Legal Guardian _____ Hm Ph_____ Wk Ph _____ Cell Ph_____

Emergency Contact Person **OTHER** than Guardian or Parent _____

Relationship: _____ Hm Ph _____ Wk Ph _____ Cell Ph _____

STUDENT'S Medical Insurance

Does your student have a KY Medicaid or K-CHIP Card? Yes / No Number _____

Does your student have other medical insurance? Yes / No Name of Company_____

STUDENT'S Medical History

1) Significant Medical History: _____

2) Medication Allergies: _____ Food Allergies: _____

3) Other Allergies: _____

4) Medications taken Daily: _____

5) * Prescription Medication to be given at School: _____

Student's Health Care Provider: _____ Phone: _____

** Must complete Medication Consent Forms prior to any prescription medications being brought to school to be administered. Forms are available at school.*

Does your student have any of the following life-threatening conditions that may require EMERGENCY treatment or medications to be given at school?

☐ **DIABETES (Glucagon)**	☐ **ASTHMA (Rescue Inhaler)**	☐ **SEIZURES (Diastat)**	☐ **LIFE-THREATENING ALLERGY (Epi-Pen)**	☐ **OTHER:** _____

CONSENT FOR HEALTH SERVICES / ASSIGNMENT OF BENEFITS

All students will receive basic First Aid and emergency care. By signing this form, I consent to School Health services given to my student by Nurses or agents of the LFCHD while at school. I authorize the LFCHD to release medical information about my student to his/her Primary Care Provider. I also understand that the information obtained from the School Physical, including Immunization information, will be released to my student's school. If I or my student has Medicaid or KCHIP, I authorize the LFCHD to release this information to Medicaid/KCHIP so that Medicaid/KCHIP can be billed for services provided by the School Nurse, at no cost to me.

I also understand that by signing this consent, I acknowledge that I have access to a copy of the Lexington-Fayette County Health Department's Privacy Notice located at www.lexingtonhealthdepartment.org or I may request a copy by calling School Health Services at 288-2314.

EXPIRES AT THE END OF EACH SCHOOL YEAR

X_____ ____/____/____

(Signature of Parent / Legal Guardian / Emancipated Student) *(Date signed)*

THIS SECTION FOR SCHOOL USE ONLY

☐ **Care Plan(s) Sent**	**Date:** _____	**Date:** _____	☐ **Care Plan(s) Returned**	**Date:** _____ **Date:** _____
	Date: _____	**Date:** _____		

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Please Return Completed Form To School Nurse