ARBOR
FAMILY HEALTH
SCHOOL-BASED CLINICS

Arbor Family Health School Based Health Centers are excited to welcome back students for the new school year!

Our school based health clinic can help children succeed by providing convenient access to healthcare, behavioral/mental health services, and dental services, all while reducing student absenteeism as well as parental leave from work.

We have two locations:

1. Livonia School Based located at 8387 Newfield Drive (near Livonia High) that services Livonia High, Valverda, and Rougon Elementary.
2. Pointe Coupee School Based located at 8430 Pointe Coupee Rd (next to STEM) that services STEM, Rosenwald, and Upper Pointe Coupee Elementary

School Based Health offers:

- Transportation to and from schools
- Well child visits, sports physicals, and preventive screenings.
- Immunizations
- Sick visits that can include in house diagnostic testing for flu, COVID-19, and strep
- Behavioral health services
- Dental services: cleanings, fillings, and x-rays
- Pharmacy Services (pick-up, delivery, or mail order)
- Telehealth/virtual visits
- Outreach Coordinator to assist with insurance applications

In order for your child to receive any of our services, the attached consent must be completed in full and returned to school or one of the two clinics.

To schedule an appointment call: 225-412-0404 for Livonia School Based or 225-638-3767 for Pointe Coupee

For more information about our other services or any questions please call 1-888-711-3785.

We look forward to providing these services for your child!

Pointe Coupee Parish School Board
Post Office Drawer 579 • New Roads, Louisiana 70760-0579
(225) 638-8674 • Fax (225) 638-3237

CONSENT FOR PROVISION OF HEALTH CARE SERVICES

The Pointe Coupee Parish School Board ("School Board") has partnered with Arbor Family Health Clinic, ("AFHC"), in order to provide students enrolled in the Pointe Coupee Parish School System, the opportunity to receive health care services at AFHC's school-based health clinics. The receipt of medical services from AFHC is strictly voluntary and is not required as a condition of enrollment in the school system. AFHC School Base will not replace your primary care physician. AFHC will provide extra medical and behavioral health services as needed. AFHC will inform the primary care physician of comprehensive exams and diagnosed conditions that may require primary care follow-up.

If you would like for your child to visit AFHC's health clinics, for purposes of receiving heath care services from AFHC, you must indicate your consent by signing this form. Please note that, after you provide your initial consent, you may be asked by AFHC to execute more detailed forms concerning your child's prior medial history before services can begin. Once all forms are satisfactorily executed, at various times throughout the school year, your child will have the opportunity to visit AFHC's clinics, which will be located near Livonia High School and next to STEM Magnet Academy of Pointe Coupee.

I hereby authorize and give consent for my child to be seen by, and to receive health care services from, AFHC at AFHC's school-based health clinics located either at LHS or STEM Magnet Academy of Pointe Coupee. I understand that these services will be provided during school hours. All health care services are provided solely by AFHC. I understand that the School Board is not involved in, or responsible for, any treatment or services provided to my child by AFHC. I further understand that, although employees of the School Board may facilitate my child's visit to AFHC's clinic, no health care services will be performed by the School Board and no employee of the School Board will accompany my child while inside the clinic. Understanding the forgoing, I hereby release the School Board from any claims or damages arising out of, or in any way related to, the services or medical treatment provided to my child by AFHC. I further consent to the transportation of my child by AFHC to and from my child's school and the clinic. I acknowledge that the School Board is not involved, in any way, with the transportation of my child to and from the clinics. I further grant the School Board permission and authority to share my child's personally identifiable information with AFHC as necessary for my child to participate in the program.

Child's Name	Parent's Name (Print)
Child's Date of Birth	Parent's Signature
Date	

ARBOR
FAMILY HEALTH
LIVONIA–POINTE COUPEE
SCHOOL BASED CLINICS

Pointe Coupee/Livonia High School Based Health Center

Consent for Transportation

I,_____(Parent/Guardian), give my permission for my child_____to be transported from their school to/and from:

Rougon Elementary 13258 LA Hwy 416 Rougon, LA 70773	Valverda Elementary 1653 Valverda Rd. Maringouin, LA 70757	Rosenwald Elementary 1100 New Roads Street New Roads, LA 70760	UPC Elementary 4339 LA Hwy 419 Batchelor, LA 70715
STEM Academy 8434 Pointe Coupee Rd. New Roads, LA 70760	Livonia High School 3118 LA Hwy 78 Livonia, LA 70755	Livonia School Based Clinic 8387 Newfield Drive, Suite A Livonia, LA 70755	Innis Dental Clinic 6450 LA Hwy 1 Batchelor, LA 70715

Pointe Coupee School Based 8430 Pointe Coupee Road New Roads, LA 70760	"Smiles-To-Go" School Based Mobile Dental Van	Mobile Medical Unit

In an Innis Community Health Center (ICHC) van to receive medical/dental services during the school year.

If you wish to revoke your consent for transportation at any time, please call the Pointe Coupee School Based Health Center at 225-638-3767/Livonia High School Based Health Center at 225-412-0404.

Child's Name (PRINT)

(Child's School and Grade)

(Child's Date of Birth)

Cindy Peavy, Executive Director

07/28/2023

Parent or Guardian Name (PRINT)

Date Signed

Parent/Guardian Signature

Kim Canezaro, Superintendent
Pointe Coupee Parish School Board

7/31/2023

Date Signed

ARBOR
FAMILY HEALTH
LIVONIA–POINTE COUPEE
SCHOOL BASED CLINICS

LOUISIANA UNIFORM CONSENT FORM FOR SCHOOL-BASED HEALTH CENTERS

Student's Name: Last	First	Middle Initial			ID# (Office use only.)
Student's Address (include city):					Zip Code:
Student's Date of Birth:	Age:	Religion:	Race:	Ethnicity:	
Birth Sex: ☐ Male ☐ Female					
Student's Social Security Number:	School:			Student's Grade:	
Preferred Language:	**Student's Email:** Type text here			**Student's Cell Phone:** ( )	
Name of Mother (include maiden name) or Legal Guardian:	Next of kin? ☐ Yes ☐ No	**Home Phone:** ( )	**Work Phone:** ( )	**Cell Phone:** ( )	Employer:
Name of Father or Legal Guardian:		**Home Phone:** ( )	**Work Phone:** ( )	**Cell Phone:** ( )	Employer:
Parent's E-mail:					
Emergency Contact:		Relationship:		Phone: ( )	
Emergency Contact:		Relationship:		Phone: ( )	
Student's Primary Care Physician:				Phone: ( )	
Student's Dentist:				Phone: ( )	
Preferred Pharmacy:	Names of siblings enrolled in School Based Health Center:				

Please check the type of health insurance your child has:

Please send a copy of insurance card (front and back) to SBHC.

☐ Medicaid/Healthy Louisiana #: _____ (check one below)
☐ Amerigroup of LA ☐ AmeriHealth Caritas LA ☐ Aetna Better Health
☐ LA Healthcare Connections ☐ United Healthcare Community Plan
☐ Medicaid (dental) #: _____
☐ No insurance
☐ Private/Other Insurance Co. Name: _____
Co. Address: _____ Phone #: _____
Policy #: _____ Group#: _____ Effective Date: _____
Name of policy holder: _____ Relationship to student: _____
Policy holder date of birth: _____ Policy holder Social Security #: _____
Does your insurance pay for prescriptions? ☐No ☐Yes

If your child does not have health insurance, would you like information on no cost health insurance? ☐ Yes ☐ No

Is your child allergic to any food or medicine? ☐ No ☐ Yes If yes, list:

List of current medications student is on with dosage (how much) and how often:

All services are provided by licensed professionals

We understand that the SBHC may participate in one or more health information exchanges (HIEs), whereby the center may share my health information with other health care providers for treatment, payment or health care operations purposes. We hereby consent to the disclosure of the SBHC's records into the HIEs.

We understand that the SBHC is funded through the Office of Public Health ("OPH") Adolescent School Health Program and, as part of such program; the SBHC is required to provide information to OPH. Therefore, we consent to the disclosure of SBHC information to OPH, or its agent, in connection with the operation, funding and ongoing monitoring of school-based health centers. We recognize that the information needed by OPH may be compiled through a HIE and consent to the disclosure of information to a HIE for such purpose.

Louisiana Law R.S. 40:31.3 states that Health Centers in schools are prohibited from:

1. Counseling or advocating abortion or referral of any student to an organization for counseling or advocating abortion.
2. Distributing any contraceptive or abortifacient drug device, or similar product**.**

To report violations of the prohibitions against abortion counseling, advocacy, or referral; or distribution of contraceptives, abortifacient drugs, devices, or other similar products, contact the Adolescent School Health Program at the Office of Public Health at 504-568-8164.

BY SIGNING THIS CONSENT, YOU ARE AGREEING TO ALLOW THE SCHOO L HEALTH CENTER TO PROVIDE THE FOLLOWING SERVICES TO YOUR CHILD:

©Primary and preventive health care ©comprehensive history and physical examinations ©immunizations
©health screenings ©laboratory/diagnostic testing ©acute care for minor illness and injury
©Administration of over the counter medication as needed ©management of chronic diseases
©behavioral health services ©health education and prevention programs ©case management
©referral and follow-up for emergencies ©referral to specialty care ©dental services (where available)
©fluoride varnish ©Patient Portal ©Telehealth ©Teledentistry
©transportation to SBHC site at Pointe Coupee Central, Livonia High, Innis Dental Clinic, and the Smiles-To-Go Van

I, as a parent/guardian, understand that I will not be charged for any of the services provided at the school based health center. I also understand that Innis Community Health Center or the physician may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to Innis Community Health Center, Inc.

By signing below, we (student and parent/guardian) acknowledge that we have read and understand the services to be provided at the school-based health center. We both give permission for this student to receive the services provided by the program.

This consent is effective while the student is enrolled in Pointe Coupee/Livonia SBHC unless the School-Based Health Center is notified in writing, that I no longer wish for my child to receive services. I understand that I may be asked to complete a one page form every school year to update important information.

We also understand that the School-Based Health Center is operated by Innis Community Health Centers, Inc. and its employees and contractors.

Printed Name of Parent/Legal Guardian	Relationship
Signature of Parent/Legal Guardian	Date
Signature of Student	Date

This consent may be withdrawn or modified at any time with written permission of the parent/guardian and student to the entity referred to above. A duplicate copy of this document will be given to parents or guardians upon request.

Office use only: Reviewed/Entered by: Date:

Effective June 2023

Office use only.

Student's Name: _____ **Date of Birth** _____

Confidentiality: The School-Based Health Centers (SBHCs) adhere to all current laws regarding confidentiality of health services in general and specifically as they relate to services to minors. All medical and mental health records are confidential and will be maintained as directed by the Health Insurance Portability and Accountability Act (HIPAA). I consent to the exchange of relevant health information between Pointe Coupee and Livonia SBHC and the student's personal medical provider upon referral for medical care. I have been given a copy of Innis Community Health Centers, Inc. Notice of Privacy Practices that describes how my health information is used and shared. I understand that Pointe Coupee and Livonia SBHC has the right to change this notice at any time. I may obtain a current copy by contacting the School-Based Health Center, at 225-638-3767\225-412-0404. My signature below constitutes my acknowledgement that I have been provided a copy of the Notice of Privacy Practices.

We consent to the exchange of relevant health information (including information about physical exams, health histories, and other information) between the school nurse and the health center staff as needed in order to facilitate evaluation of this student's health needs, special education multi-disciplinary evaluations, disciplinary referrals, attendance records, and immunization records. We understand that due to the confidential nature of services provided at the health center, only information regarding crisis or threat of grave or serious harm to self or others will be shared with the school principal.

The school board and the school health center hereby agree that all medical information of the student is hereby declared confidential and may not be disseminated to any other person, firm, or organization other than I) a healthcare provider (for diagnosis, treatment, or counseling purposes): (2) the authorized insurance or benefit payer or health care service plan which is liable for payment; or (3) the spouse, parent/guardian of the minor student. Although nothing herein contained may prohibit the treatment by a licensed physician of someone in a true emergency situation within the meaning of the Louisiana Emergency Treatment Act, visits and/or treatments must be disclosed to the parents as soon as reasonably possible after the visit and/or treatment, through a reasonable effort by written notice via the child to the parents/guardian and/or a phone call to the parents/guardian. The medical information obtained may not be used for any other purpose than the health examination, diagnosis and treatment by a licensed health care provider. The provisions of this paragraph do not apply in cases involving child abuse by a parent/guardian. Any medical information used for purposes of surveys or evaluating school health center performance will keep the identity of students anonymous, including references to social security numbers or other identification methods. Nothing herein contained shall constitute a medical consent to give supplies to a minor involving contraception, abortion, premarital sex, nor may an examination or treatment be made for the purpose of determining in whether counseling for such services or supplies is or is not appropriate. Nothing in this paragraph shall invalidate Consent given on the Attachment.

At any time, the parent or guardian or minor themselves may refuse to provide information, including, but not limited to, long term medical history of the child and family members if the child chooses to do so or the parent restricts or prohibits the disclosure of such information. The limitation is not intended to prohibit the parent or child from giving medical history pertaining to the specific reason or purpose the child seeks medical treatment. I have read and understand the information in this form. I give permission for my child to have medical treatment at the Pointe Coupee /Livonia High-School Based Center. I am the legal guardian of the child.

I acknowledge receipt of the Notice of Privacy and understand I may call the Pointe Coupee SBHC at 225-638-3767/Livonia High SBHC at 225-412-0404 to have any questions answered regarding The Notice of Privacy.

Signature: _____ **Date:** _____

Your Name (Please Print): _____

ARBOR FAMILY HEALTH
LIVONIA–POINTE COUPEE SCHOOL BASED CLINICS

Pointe Coupee/Livonia High School Based Health Center

STUDENT NAME: _____ DOB: _____ GRADE: _____

Student Medical History (*Please indicate which of the following medical conditions your child has been treated for or you have concerns your child might have)*

Y	N	Medical Condition	Y	N	Medical Condition
		Abnormal Bleeding			Ear Infections
		ADHD/ADD			Hearing Loss
		Allergies			Speech Problems
		Asthma (Please bring inhaler to clinic)			Mental Health Concerns/Depression
		Birth Defect			Physical Disability
		Brain/Head Injury			Respiratory (Lung Problems)
		Broken Bones			Rheumatic (Scarlet) Fever
		Cardiovascular (Heart) Problems			Seizures
		High Blood Pressure			Sickle Cell Disease
		Dental Disease			Vision Problems/Eye Disorders
		Diabetes			Staph Infection (Abscess or Boil)
		Eating Problems/Poor appetite			COVID-19:
					Other:

Student Surgical & Hospitalization History

Has your child ever had surgery? *(If yes, please specify below)* ☐ Yes ☐ No

Y	N	Surgery	Y	N	Surgery
		PE Tubes (Tubes in Ears)			Adenoidectomy
		Appendectomy			Bone or Joint Surgery
		Tonsillectomy			Other:

Has your child ever been admitted into a hospital? *(If yes, please specify below)* ☐ Yes ☐ No

Hospital	Date	Reason

Family Medical History *(Which of the following medical conditions apply to you or an immediate family member)*

Y	N	Condition & Details	Relationship to Student (Mother, Sister, etc.)	Y	N	Condition & Details	Relationship to Student (Mother, Sister, etc.)
		Asthma				Diabetes	
		Cancer				Seizures	
		High Blood Pressure				Sudden death before age 50	
		Heart Disease/Heart Attack				Sickle Cell	
		Emotional/Mental Health Concerns				Tuberculosis	
		Nervous/Mental Disorder				Other:	
		Other:				Other:	

Signature of Parent/Guardian _____ **Date** _____

Contact Number _____

ARBOR
FAMILY HEALTH
LIVONIA–POINTE COUPEE
SCHOOL BASED CLINICS

Request to Immunize

Patient Name: _____ Date of Birth _____

We are pleased to assist you in keeping your child healthy by completing immunizations that will be due this school year. Signing this form indicates that you will receive the VIS forms prior to administering immunizations and you request the School-Based Health Center give your child CDC recommended vaccines including:

Required Vaccines:

HepA (Hepatitis A) Meningococcal
HepB (Hepatitis B) Varicella (chickenpox)
Tdap (Tetanus, diphtheris, acellar pertussis)
MMR (Measles, mumps, rubella)
Polio
DTaP (Diphtheria, tetanus & acellular pertussis)

Recommended Vaccines: Check Yes or No

HPV (Human papillomavirus) **YES__NO__**
Influenza **YES___NO_____**

Please answer the questions below by circling "yes" or "no"

Has your child ever had the chickenpox disease?	Yes	No
Does your child have any allergies to medication, food or vaccine?	Yes	No
Has your child had a serious reaction to a vaccine in the past?	Yes	No
Has your child had a seizure or a brain problem?	Yes	No
Does your child have Cancer, Leukemia, AIDS or any other immune problem?	Yes	No
Has your child taken cortisone, prednisone, other steroids, or anticancer drugs, or had x-ray treatments in the past 3 months?	Yes	No
Has the student received a transfusion of blood or blood products or been given immune (gamma) globulin in the past year?	Yes	No
Is your child pregnant or a chance she could become pregnant in the next month?	Yes	No
Has your child received vaccinations in the past 4 weeks?	Yes	No
Is your child allergic to eggs\chicken?	Yes	No

What Doctors office did your child receive his/her childhood vaccines?_____

If you have any updated records at home, please send them to school with your child. We will make a copy and return your original.

If you would like the Pointe Coupee & Livonia SBHC to administer vaccines, please sign below. There is no cost to you for this service. Please call 225-638-3767 or 225-412-0404 if you have any questions or concerns.

Student Name_____ Date of Birth_____

I, (PARENT/GUARDIAN NAME) _____ give permission for my child to receive immunizations at the Pointe Coupee & Livonia SBHC. Please sign below as receipt of Vaccine Information Statements.

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

06/2023

SCHOOL BASED MOBILE DENTAL PROGRAM

ARBOR FAMILY HEALTH

A DIVISION OF INNIS COMMUNITY HEALTH CENTERS, INC.

SMILES-TO-GO

ID# (Office use only)

NAME OF SCHOOL:_____

(SCHOOL ATTENDED LAST YEAR):_____

DENTAL CONSENT FORM

Student Name: **Student DOB:**

STUDENT DENTAL HISTORY: (CIRCLE THE APPROPRIATE ANSWER)

1. Does your student he/she sees routinely? ..... YES NO
   If YES, please list Dentist _____
2. When did your student last have their teeth cleaned? .....6 MONTHS 12 MONTHS NOT SURE
3. When did your student last have dental x-rays taken?.....6 MONTHS 12 MONTHS NOT SURE
4. How often does your student eat sweets, mints, or chew gum?.....DAILY WEEKLY MONTHLY HARDLY EVER
5. How often does your student drink soda or other sweet drinks?.....DAILY WEEKLY MONTHLY HARDLY EVER
6. Has your student ever received an injection to numb teeth? .....YES NO
7. Is your student allergic to latex?.....YES NO
8. Does your student have problems with bleeding gums when flossing or brushing?.....YES NO
9. Does your student have a fear of Dental Care? .....YES NO
10. Does your student have pain or discomfort in any teeth now? .....YES NO
    If so, where?_____
11. Has your student ever had any injuries to the face, mouth, or teeth? .....YES NO
    If so, where?_____
12. Has your student ever experienced any complications of any kind during dental treatment?.....YES NO
    If so, where and what happened?_____

Please check the type of dental health insurance your child has:	Medicaid/LaCHIP #:_____ No insurance Private/Other Insurance Co. Name:_____ Co. Address:_____ Phone #:_____ Policy #_____ Group #:_____ Effective Date:_____ Name of policy holder:_____ Relationship to student:_____ Policy holder date of birth:_____ Policy holder Social Security #:_____

ALL SERVICES ARE PROVIDED BY LICENSED PROFESSIONALS

SERVICES BY INNIS COMMUNITY HEALTH CENTERS, INC WILL BE PROVIDED ONLY WITH THE CONSENT SIGNED BY THE PARENT/LEGAL GUARDIAN.

The Mobile Dental Program offers the following services:

v oral examinations v x-rays v dental cleanings v dental sealants (plastic protective coatings) v Teledentistry
v fluoride treatments v fillings and other restorations v extractions (tooth removal) v referral to specialty care

Circle any specific services that you DO NOT want your child to receive.

- v Some dental treatment may be done using a local anesthetic (injection to numb teeth). Difficulties with local anesthetics are rare.
- v If needed, your child may be provided with an over-the-counter medicine- Tylenol or Motrin. Circle **yes or no** if you give permission to administer such analgesics (pain medicine). **YES NO**
- v No laughing gas or sedative drugs are used in our dental facilities.

As with any health care procedure, there are risks associated with any dental treatment. Please contact Mobile Dental Unit with any questions, concerns, or complications related to the care of your child at Main campus **225-492-3775**.

The Mobile Dental Program provides quality care, comfort, and convenience. **TURN PAGE OVER**

I have read and understand the information in this form. I give permission for my child to have dental treatment on the (Smiles-To-Go) Innis Community Health Centers, Inc . I acknowledge receipt of the Notice of Privacy and understand I may call the Mobile Dental Program at 225-492-3775 (Main campus) to have any questions answered regarding the Notice of Privacy. I am the legal guardian of the child.

Signature*:_____ Date:_____

Your name (please print): _____

ARBOR
FAMILY HEALTH
LIVONIA–POINTE COUPEE
SCHOOL BASED CLINICS

(INK ONLY)

OFFICE USE ONLY

Student Name: 2nd Indentifier:

Last First

I, as parent/guardian, understand that I will not be charged for any of the services provided through the health center. I also understand that Innis Community Health Centers, Inc, Mobile Dental Program may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to Innis Community Health Centers, Inc.

We (student and parent/guardian) have read and understand the services to be offered at the school health center. We both give permission for this student to receive the services offered by the program. We also understand that the Mobile Dental Unit is operated by Innis Community Health Centers, Inc and its employees and contractors. Innis Community Health Centers, Inc is a Federally Qualified Health Center that works within identified schools of the Pointe Coupee Parish School System through an intergovernmental agreement. Innis Community Health Centers, Inc maintains a local volunteer Board of Directors and its own liability, malpractice and Director's and Officer's insurance. Innis Community Health Centers, Inc Mobile Dental Program may be contacted by calling the Main Campus at 225-492-3775.

This consent is effective while the student is enrolled in the Innis Community Health Centers, Inc Mobile Dental Smiles-To-Go program unless the Innis Mobile Dental-Smiles To Go is notified in writing, that I no longer wish for my child to receive services. I understand that I may be asked to complete a one page form every school year to update important information.

_____ Relationship: _____

Printed Name of Parent/Legal Guardian

_____ Date: _____

Signature of Parent/Legal Guardian

This consent may be withdrawn or modified at any time with written permission of the parent/guardian and student to the entity referred to above. A duplicate copy of this document will be given to parents or guardians upon request.

SMILES TO GO------- 225 492-3775- ADMIN OFFICE - 6450 LA HWY 1, Suite B, INNIS, LA 70747

ARBOR FAMILY HEALTH
LIVONIA–POINTE COUPEE SCHOOL BASED CLINICS

DENTAL HEALTH HISTORY

STUDENT NAME: _____ DOB: _____ GRADE: _____

Student Medical History (*Please indicate which of the following medical conditions your child has been treated for or you have concerns your child might have)*

Y	N	Medical Condition	Y	N	Medical Condition
		Abnormal Bleeding			Ear Infections
		ADHD/ADD			Hearing Loss
		Allergies			Speech Problems
		Asthma (Please bring inhaler to clinic)			Mental Health Concerns/Depression
		Birth Defect			Physical Disability
		Brain/Head Injury			Respiratory (Lung Problems)
		Broken Bones			Rheumatic (Scarlet) Fever
		Cardiovascular (Heart) Problems			Seizures
		High Blood Pressure			Sickle Cell Disease
		Dental Disease			Vision Problems/Eye Disorders
		Diabetes			Staph Infection (Abscess or Boil)
		Eating Problems /Poor appetite			COVID-19
					Other:

Student Surgical & Hospitalization History

Has your child ever had surgery? ***(If yes, please specify below)*** ☐ Yes ☐ No

Y	N	Surgery	Y	N	Surgery
		PE Tubes (Tubes in Ears)			Adenoidectomy
		Appendectomy			Bone or Joint Surgery
		Tonsillectomy			Other:

Has your child ever been admitted into a hospital? ***(If yes, please specify below)*** ☐ Yes ☐ No

Hospital	Date	Reason

Family Medical History *(Which of the following medical conditions apply to you or an immediate family member)*

Y	N	Condition & Details	Relationship to Student (Mother, Sister, etc.)	Y	N	Condition & Details	Relationship to Student (Mother, Sister, etc.)
		Asthma				Diabetes	
		Cancer				Seizures	
		High Blood Pressure				Sudden death before age 50	
		Heart Disease/Heart Attack				Sickle Cell	
		Emotional/Mental Health Concerns				Tuberculosis	
		Nervous/Mental Disorder				Other:	
		Other:				Other:	

Please list any current medications: _____

_____

Please list any allergies: _____

_____

Signature of Parent/Guardian _____ **Date** _____

Contact Number _____