



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. If my student attends a school that has a specialized nursing clinic overseen by a Nurse Practitioner, I also consent to care which may include tests for diagnostic screening (i.e. strep). 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 ONE YEAR AFTER DATE SIGNED

X _____
(Signature of Parent / Legal Guardian / Emancipated Student)

_____/_____/____
(Date signed)

THIS SECTION FOR SCHOOL USE ONLY

Care Plan(s)
Sent

Date: _____
Date: _____

Date: _____
Date: _____

Care Plan(s) Returned
Date: _____

Date: _____