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

STUDENT VISIT HEALTH INQUIRY AND CONSENT FOR CARE

Dear Parent/Guardian: Thank you for taking the time to fill out this brief health information history on your child prior to visiting our school program at LABBB. This information will help the school nurses better understand your child and prepare for the upcoming visit.

Student name: _____ Birth date: _____
School Program & Location: _____

Does your child have any **ALLERGIES**? If yes, please list: _____

Does your child have an EpiPen? ☐ YES ☐ NO

A **life threatening allergy** to food, latex, or stinging insects requires an **Allergy Action Plan** and **medication order for an EpiPen** be in place prior to visiting our program.

Does your child have a history of **seizures**? ☐ YES ☐ NO
If yes, a **Parent Seizure Questionnaire** is needed prior to visit.

Does your child have an emergency seizure medication? ☐ YES ☐ NO
(i.e. Diastat, Midazolam, etc.)

If yes, a **Seizure Action Plan** and **medication order** for the applicable emergency medication is needed prior to visit. Please contact the LABBB Health Office as soon as possible.

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 prior to visit.

Does your child need to take any **medications** during the visit? ☐ YES ☐ NO

If a medication is needed at school, a **medication order** from your student's doctor is needed prior to visit. Please contact the LABBB Health Office as soon as possible.

Parent/Guardian Authorization for Health Care Services

I, the undersigned, give permission for the LABBB nurses/building nurses to provide treatment to my child should an illness or injury occur during the school visit. In the event that I cannot be reached, I also authorize the LABBB nurses/building nurses to seek further medical treatment on my child's behalf when deemed immediately necessary.

Parent/Guardian signature: _____ **Date:** _____

Parent/Guardian telephone(s): _____