A TRADITION OF EXCELLENCE FOR ALL

LCS

LYNCHBURG CITY SCHOOLS

Health Alert Form
2025-26 School Year

Student Name:_____ DOB: _____
School Name: _____ Teacher: _____ Grade: ____
Parent/Guardian Name: _____ Relationship: _____
Primary Phone #: _____ Secondary Phone # _____

Health Insurance: (**please circle**) Private Medicaid Famis None
Other:_____

Does your child have an **IEP**: Yes No

Does your child have a **504**: Yes No

****Does your child have any type of Health Concerns?** Yes No

(****If you circled "YES" above, please see the note below.**) **Please Circle and/or List**

Asthma	**YES**	**NO**	**Notes:**
Use Inhaler?	Yes	No	
Diabetes	**YES**	**NO**	**Notes:**
Use Insulin?	Yes	No	
Use Insulin Pump?	Yes	No	
Use Continuous Glucose Monitor (CGM)?	Yes	No	
Seizures	**YES**	**NO**	**Notes:**
Use Valtoco or Diastat?	Yes	No	
Tracheostomy	**YES**	**NO**	**Notes:**
Use Oxygen?	Yes	No	
Allergies	**YES**	**NO**	**Please List:**
Use Epi-Pen?	Yes	No	
Other Health Concerns	**YES**	**NO**	**Please List:**

In case of emergency, I hereby authorize the person(s) listed below to pick up my child or for Lynchburg City Schools to transport my child and/or to call EMS for my child to be taken to the nearest hospital.

Name two (2) people who are authorized to pick up your child if necessary:

Name: Relationship: Phone #:
Name: Relationship: Phone #:
Parent/Guardian Signature: Date:
Please PRINT Name: Relationship:

****Note – Please see School Nurse to obtain any necessary forms; All Health Action Plans and Physician/Parent Authorization to Administer Medications at School forms MUST BE updated by your child's physician and returned to the school clinic at the beginning of each new school year. All medications and supplies needed by the student must be provided by the parent/guardian.**