LAST NAME:

Reviewed by/date

STUDENT HEALTH INFORMATION
2020-2021

Student Name: _____ **Birth Date:** _____ ☐ **Male** ☐ **Female Grade:**_____

Parent/Guardian: _____ **Phone- Home:** _____ **Work:** _____ **Cell:** _____

Dear Parent/Guardian,
Your child's health may affect his or her learning. Health information is important in planning for your child's needs at school. Your input and involvement are important. Please complete this form and return it to school as soon as possible.

HEALTH CONCERNS: Please mark an "X" and explain if your child has any of the following:

Yes	No	
☐	☐	Attention Deficit Hyper-activity Disorder/Attention Deficit Disorder (ADHD/ADD)
☐	☐	Allergies* (to what? _____)
☐	☐	Has the allergy been diagnosed by a doctor?
☐	☐	Medication for allergy: _____ ***Complete allergy action plan if appropriate***
☐	☐	Food Intolerance? Describe: _____
☐	☐	Asthma or other breathing problems: ***Complete asthma action plan if appropriate***
☐	☐	Has asthma been diagnosed by a Health Care Provider?
☐	☐	Currently has an inhaler?
☐	☐	Ever hospitalized for asthma? If so, when was last hospitalization? _____
☐	☐	Other breathing problem (describe): _____
☐	☐	Diabetes: ❒ Type 1* ❒ Type 2 ****Must complete diabetes emergency plan.*** Managed by: ❒ Diet/Activity ❒Oral meds ❒ Insulin injections ❒ Insulin Pump
☐	☐	Heart Conditions: _____
☐	☐	Seizures: Date & type of last seizure: _____ ****If yes must complete seizure action plan.***
☐	☐	Has your child ever had a concussion or head injury?
☐	☐	Social/emotional/behavioral/mental health concerns: _____
☐	☐	Is there a current concern that your child has been a ❒ target of / ❒ instigator of bullying?
☐	☐	Recent surgeries or hospitalizations: _____
☐	☐	Activity restrictions: _____
☐	☐	Receives Special Education /IEP/504 Services
☐	☐	Other health concerns: _____

EMERGENCIES: Does your child have a known health problem that could result in an emergency? ❒ **Yes*** ❒ **No**

**** Must complete emergency action plan***

Please describe: _____

MEDICATIONS:

First, list ALL medications that your child takes: _____

Now, list **ALL** medications that your child needs DURING THE SCHOOL DAY. An authorization with parent and health care provider consent is required each school year for all the following listed prescription AND over-the-counter medications***. A new consent is needed each school year.***

_____

Please complete and sign back of form

Vision:
- ☐ Glasses/contacts prescribed
- ☐ Wears glasses/contacts all of the time
- ☐ Wears glasses in classroom only
- ☐ No vision problem
- ☐ Request assistance obtaining glasses

Hearing:
- ☐ Frequent ear infections (more than 3 per year in past year)
- ☐ Has ear tube(s)
- ☐ Hearing loss ☐ right ear ☐ left ear
- ☐ Hearing aid(s) ☐ right ear ☐ left ear
- ☐ No hearing problem

HEALTH INSURANCE: (Circle)

My child has health insurance: Yes No

I request assistance with health insurance: Yes No

HEALTH CARE PROVIDERS:

Does your child have a doctor or clinic where they usually go for health care? Yes No
If yes, please complete the following:

Primary Heath Provider	**Location and Phone**
Dental Provider	**Location and Phone**
Other	**Location and Phone**

Hospital preference_____

I attest to the information provided and give permission for its release for confidential use in meeting my child's health and educational needs in school. I acknowledge that it is my responsibility to inform the school of any changes to the health status of this student including health conditions, needs, and/or allergies.

Parent/Guardian signature: _____ **Daytime phone:** _____

Print Parent/Guardian name: _____ **Date:** _____

Parent/Guardian e-mail contact: _____

Comments: _____

The school intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested information—there will be no consequences—it may result in an incomplete health and safety plan for your child. The information you provide will one be shared with those whose jobs require access to this information to ensure your child's safety and school success. (MS section 13.04, Subdivision2)