HEALTH INFORMATION FORM

______________________ ______________________ ______________________
First *Middle* *Last*

______________ ☐ Male ☐ Female
Date of Birth

____ ______________ ____________________
Program *Grade/Room* *School Attended Last Year*

Dear Parent/Guardian,

A student's health may affect his or her learning. Therefore, health information is important for the student's needs at school. Health information from this form may be shared with other school staff as needed.

Please complete this form and return it to the school as soon as possible.

HEALTH CONCERNS
Please make a ☑ if the student has any of these overall health concerns:

☐ No Health Concerns

☐ ADHD/ADD

☐ Allergies (please list) ____

☐ Asthma or breathing problems
Has the student ever been diagnosed by a doctor as having asthma? ☐ Yes ☐ No
Has the student had episode(s) of wheezing (whistling in chest) in the last 12 months? ☐ Yes ☐ No
In the last 12 months, have you heard the student wheeze or cough after active playing? ☐ Yes ☐ No
Other breathing problem (describe) ____

☐ Bladder problems/Bowel problems (describe) ____

☐ Diabetes ☐ Type 1 ☐ Type 2
Managed by ☐ Diet only
☐ Oral Meds
☐ Insulin Injections
☐ Insulin Pump

☐ Exposure to drugs and/or alcohol before birth ____

☐ Heart problems (describe) ____

☐ Pregnancy Due Date: ______________
Has children; Age(s) of Child(ren): ______________

☐ Seizures (describe) ______________________________ Date of last seizure ______________

☐ Social/emotional/behavioral/mental health concerns (describe) ____

☐ Other health concerns or significant history of problems (describe) ____

☐ Activity restrictions (describe) ____

☐ Recent surgeries or hospitalizations (explain) ____

EMERGENCIES
Does the student have a health problem that could result in an emergency?
☐ Yes ☐ No
If yes, please describe ____

MEDICATIONS

List ALL medications that the student takes every day or when needed. A consent form is required for all medication taken at school, including over the counter medications. The consent form must be signed both by the health care provider and by the parent/guardian. A new consent form is needed each school year. Forms are available in the health office and on the school website.

MEDICATION NAME	PURPOSE	DOSE	FREQUENCY	@ SCHOOL?	AM	PM

VISION

- ☐ No vision problem
- ☐ Glasses/contacts prescribed
- ☐ Wears glasses/contacts all of the time
- ☐ Wears glasses in classroom only
- ☐ Glasses lost/broken
- ☐ Has or had glasses but does not wear
- ☐ Other (describe)

HEARING

- ☐ No hearing problem
- ☐ Frequent ear infections (more than 3 in the past year)
- ☐ Has ear tube(s)
  Date inserted: ___________________
- ☐ Hearing Loss
  ☐ Right Ear ☐ Left Ear
- ☐ Hearing Aid(s)
  ☐ Right Ear ☐ Left Ear
- ☐ Hearing Aid(s) lost/broken
- ☐ Has or had hearing aids but does not wear
- ☐ Other (describe)

COMMENTS

Use this space to describe problems listed.

____

EMERGENCY CONTACT INFORMATION

_______________________ Name _______________ Phone

_______________________ Name _______________ Phone

HEALTH CARE PROVIDERS

Does the student have a doctor or clinic where they usually go for healthcare? ☐ Yes ☐ No

PROVIDER	NAME OF DOCTOR/CLINIC	LOCATION & PHONE	APPROX. DATE OF LAST EXAM
Primary Health Provider			
Eye Specialist			
Ear Specialist			
Other Specialist (please specify)			

Hospital Preference _______________________________________

This health information may be shared with school staff as needed. If you do not want this information shared, please contact the school nurse at **swmetronurse@swmetro.k12.mn.us** | (952) 567-8009

_______________________ *Parent/Guardian Signature* _______________ *Date*

_______________________ *Parent/Guardian Name* _______________ *Email* _______________ *Daytime Phone*