



Sauk Rapids-Rice Schools – ISD #47

Health Information Form

This form is confidential

Personal	Name:	Birthdate:	Male	Female
	Address:	Phone:		
	Parent/Guardian:			
	Doctor:	Dentist:		
	Last Physical Exam:	Last Dental Exam:		

Significant History	Condition/Year	Condition/Year
	Allergy (specify)	ADHD/ADD
	Asthma	Developmental Delay
	Chicken Pox (disease)	Seizure History
	Congenital Defect (specify)	Vision Glasses ___ Yes
	Diabetes	Hearing
	Heart Condition	Surgeries (specify) T & A Myringotomy Tubes Hernia
	Neurologic (specify)	
	Orthopedic (specify)	
Other:		

Health Examination	Health Examination (this portion to be completed by physician)					
	Examining Physician's Name:					
	Ht.	Wt.	Pulse	BP	Urinalysis	HGB
	Eyes	Nutrition				
	Ears	Orthopedic/Scoliosis				
	Nose	Skin				
	Throat	Allergies (specify)				
	Glands	Serious Illnesses				
	Lungs					
	Heart					
	Nervous System	Other				
	Significant History					
	Developmental					
	Social/Emotional					
Hearing Problem			Speech Problem			

Activity Clearance	List conditions which may limit participation in:	
	Classroom activities:	
	Physical Education:	
	Competitive Sports:	
	List any special health problems, recommendations and/or comments:	
Child is approved for:		
Full Activity		
Limited Activity		

Medication	Does child require medication on a daily or episodic routine?	
	Name of medication:	
	Dose:	Frequency
	Condition being treated:	
<i>Please include a separate doctor's order if medication will be taken at school.</i>		

Date: _____ Examining Physician: _____, M.D.

I hereby release this information to the Health Services of ISD #47 and give the licensed school nurse permission to clarify the information with the physician if the need arises.

Parent/Guardian Signature _____