SAUK RAPIDS-RICE PUBLIC SCHOOLS

STORM

A path for every student.

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:**		

	Condition/Year	Condition/Year
Significant History	**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					
	Lungs			**Serious Illnesses**		
	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:	
	Please include a separate doctor's order if medication will be taken at school.	

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 _____