Forest Lake Area Schools

Confidential Student Health Information

Secondary School Year: _____

Student Name: _____ Birth Date _____ M ☐ F☐
Last First Middle

Parent/Guardian: _____ Grade: _____

1st number to call if your child is ill or injured: _____ School attended last year: _____

Dear Parent/Guardian:
Your child's health may affect his or her learning. Therefore, health information is important in planning for your child's needs at school. To ensure the best care for your child, your input and involvement is important. Please continue to update health staff as your child's health needs develop or change. Complete this form and return it to the Health Office.

NO HEALTH CONCERNS

☐ **My child has no health concerns.** Please check box, review and **sign the back of the form**

HEALTH CONCERNS

Please ✓ and explain if your child has any of the following:

☐ Allergies (to what? foods, bee stings….) _____

A food allergy will require a Special Diet Statement form signed by a medical authority

Epi-Pen Needed: ❒ Will be kept in Health Office ❒ Self-carry, Dr. order needed

☐ Asthma or other breathing problems: _____

Inhaler Needed: ❒ Will be kept in the Health Office ❒ Self-carry ❒ Self -administer/ Dr. order needed

☐ Lactose Intolerant: _____ Special Diet Statement NOT needed

☐ Diabetes: ❒ Type 1 Managed by: ❒ Insulin injections ❒ Insulin Pump ❒ Continues Glucose Monitor
❒ Type 2 Managed by: ❒ Diet only ❒Oral meds

☐ Heart Problems: _____ Medication: ❒ Yes ❒ No

☐ Concussion/Brain Injury: _____ Date of injury: _____

☐ Seizures: Type: _____ Date of last seizure: _____

Emergency medication needed: _____

☐ Attention Deficit Hyper-activity Disorder/Attention Deficit Disorder (ADHD/ADD)

☐ Social/emotional/behavioral/mental health concerns: _____

_____

☐ Surgeries or hospitalizations: _____

☐ Activity restrictions: _____

☐ Receives Special Education /IEP/504 Services: _____

☐ Other health concern or significant history of problems: _____

Complete Back of Form

MEDICATIONS: Throughout the year please notify the health office of any medication and/or dosage change.

Please list ALL medications that your child takes at home: _____

_____

Please list **ALL** medications that your child needs DURING THE SCHOOL DAY. A completed Authorization for Administration of Medication at School is required each school year for prescription AND over-the-counter medications.

_____

- All Medications that are considered a **Controlled Substance** will need to be brought to the Health Office by a **parent/guardian** and counted with a designated district staff member.
- In order to self-carry or self-administer medication a physician order & school nurse approval is required.
- Middle School & High School Students: Certain over- the- counter medications need parental consent only. Contact the school Health Office or access the District Web-Site for further information.

All forms can be requested from the health office and also found on the District website in Health Services

Vision: Date of last exam_____ ☐ No vision problem ☐ Wears glasses or contact

Hearing: Date of last exam_____ ☐ No hearing problem ☐ Hearing loss R/L ☐ Wears hearing aid R/L

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

If yes, describe: _____

Health Care Providers:
Does your child have a doctor or clinic where they usually go for health care? ☐ Yes ☐ No

Name of Doctor or Clinic	Location & Phone	Date of Last Exam
Primary:		
Specialist:		

Note: If a health condition is serious enough to be life threatening, the parent/guardian is responsible for sharing necessary health information with programs that take place outside of the educational day, including but not limited to, the bus service, before and after school program staff, community education staff and PTA programs.

I attest to the above information and give permission for its release for confidential use in meeting my child's health and educational needs in school. (If you do not give permission for release, contact school administration) I will contact the health office if my child's health needs change through out the year.

Parent/Guardian signature _____ Daytime phone _____

Print Parent/Guardian name: _____ Date: _____

Parent/Guardian e-mail contact: _____

☐ I understand that typing my name in the signature box above constitutes a legal signature confirming that I acknowledge and warrant the truthfulness of the information provided in this document.