Forest Lake Area Secondary Schools

Confidential Student Health Information

School Year _____

Student Name: _____ Birth Date: _____

Last First Middle

Parent(s)/Legal Guardian(s): _____ Grade: _____

1st number to call if your child is ill or injured: _____ 2nd number: _____

Parent(s)/Legal Guardian(s):

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.

HEALTH CONCERNS

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

HEALTH CONCERNS

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

□ Allergies: If so, to what? _____

Is an **Epi-Pen** Needed? □ Yes □ No If yes: □ Will be kept in Health Office □ Self-Carry/Self-Administer

If your child will need a complete food substitution due to a food allergy, a Special Diet Statement form is required to be on file and signed by a medical provider. You can in the form on the FLAS Nutrition Services Webpage

□ Asthma or other breathing problems: _____

□ Is an **Inhaler** Needed? □ Yes □ No If yes: □ Will be kept in Health Office □ Self-Carry/Self-Administer

□ Lactose Intolerant (Special Diet Statement NOT needed)

□ Diabetes: □ Type 1 Managed by: □ Insulin injections □ Insulin Pump □ Continuous Glucose Monitor

□ Type 2 Managed by: □ Diet □ Oral meds

□ Heart Problems: _____ Medication: □ Yes □ No

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

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

Emergency Medication Needed? □ Yes □ No If yes: □ Will be kept in Health Office □ Self-Carry/Self-Administer

□ Attention Deficit Hyperactivity 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

ALL medications that are given at school require a signed *Authorization for Administration of Medication at School* form each year for prescription AND over-the-counter medications (This also includes medications such as: Tums, Cough Drops, Skin Creams, etc). Prescription medications must also have a signed physician's order.

In order for a student to self-carry or self-administer a medication, a physician order and school nurse approval is required.

All medications that are considered a **Controlled Substance** will need to be brought to the Health Office by a **parent/legal guardian** and counted with a designated district staff member

Please list all medications that your child needs DURING THE SCHOOL DAY: _____

_____

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

_____

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

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/legal 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 throughout the year.

Parent/Legal Guardian signature _____ Daytime phone _____

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.

Print Parent/Legal Guardian name: _____ Date: _____

Parent/Legal Guardian email contact: _____