ANNUAL STUDENT HEALTH INFORMATION

Student Name_____ **Birthdate**____/____/____ **Student ID**_____ **School Year** _____
Gender: M or **F** **School**_____ **Grade**_____ **Classroom Teacher/Advisory**_____

Health Care Provider/Clinic Name_____
Health Care Specialists (neurology, behavioral, orthopedic, etc.)/Clinic Name(s)_____
☐ My child has no health concerns

Check any current health condition listed below about which the school should be aware:

☐ **Seizures/Epilepsy:** Emergency Medication: Yes or No
☐ **Diabetes:** Insulin pump Pen CGM
☐ **Life Threatening Allergy:** _____ EpiPen Benadryl Other: _____
☐ **Food Intolerance/Sensitivity:** _____ Reaction: _____
☐ **Asthma:** Inhaler Nebulizer
☐ **Other (Sickle Cell, Hemophilia, Adrenal Insufficiency, Tube Feeding, Catheterization, Cardiac, Visual Impairment, Kidney, Central Line, Private Duty Nurse, etc):**

_____

If your child has one of the above conditions, please contact the licensed school nurse and your child's health care provider for medication authorization and emergency action plan.

☐ ADHD
☐ Anxiety
☐ Autism
☐ Concussion: Date _____
☐ Depression
☐ Ear Tubes: Placement Date _____
☐ Headaches/Migraines
☐ Orthopedic _____
☐ Seasonal/Environmental Allergies
☐ Hearing Aids
☐ Vision: Glasses Contacts

Does your child have any disabilities, physical limitations, developmental delays or sensory concerns? Yes or **No**
If YES, please explain:

_____

MEDICATIONS YOUR CHILD TAKES:	REASON FOR MED	TAKEN DAILY	TAKEN AS NEEDED

Consent to Share Immunization Information: Your child's school is asking your permission to share your child's immunization record with Minnesota's Immunization registry to help us better protect students from disease. This is a voluntary consent. All information is considered private data and can only be released with authorization.

I agree to allow school personnel to share my student's immunizations record with Minnesota's Immunization Registry.

☐ I Do Authorize ☐ I Do Not Authorize

PLEASE PROVIDE A COMPLETE LIST OF CHILD'S IMMUNIZATIONS UPON ENTRANCE TO KINDERGARTEN, GRADE 7, GRADE 12, AND STUDENTS NEW TO THE DISTRICT.

Please remember to inform your child's bus driver if your child has a condition that may lead to an emergency situation on the bus. No medications, prescription or over the counter, are given to a student unless prescribed by the child's health care provider and provided by the parent. Annual written consent to dispense medication is required. Medication given at school must be brought to school by the parent in a pharmacy labeled bottle. The above information may be shared with staff.

Parent/Guardian
Signature_____**Date**_____

Update: 4/12/23