



## Orono Schools Annual Verification of Health Information

School Year \_\_\_\_\_

<b>Student Information</b>				
Last Name	First Name	Middle Name	Date of Birth	Grade
<b>Health Concerns</b>				
Acute illness, injuries or operations this past year: <input type="checkbox"/> No <input type="checkbox"/> Yes - Explain:				
Past Health Concerns - Explain:				
Current Health Concerns - Explain:				
Asthma: <input type="checkbox"/> No <input type="checkbox"/> Yes - Please explain and include MD signed medical documentation				
My student is carrying their own inhaler (physician's note required): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				
Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes - Please explain and include MD signed medical documentation				
My student is carrying their own emergency epinephrine (physician's note required): <input type="checkbox"/> Yes <input type="checkbox"/> No				
Activity Restrictions:				
Glasses or Contacts: <input type="checkbox"/> No <input type="checkbox"/> Yes - Explain:				
Hearing/Ear Concerns: <input type="checkbox"/> No <input type="checkbox"/> Yes - Explain:				
Immunizations received during the past year - please list type and date (month/day/year):				
<b>Physician and Clinic Information</b>				
Physician:		Clinic:		Clinic Phone:
Hospital Preference:		Dentist:		Dentist Phone:
<b>Medications</b> (Refer to Orono School District Policy #516 - Student Medication)				
Medications given at home and for what reason:				
Medications to be given at school and for what reason (separate physician's note and parent signature required):				

The information that you supply will be used by the School District to address health and safety issues pertaining to your child. This data may be shared with health service staff, administration and other staff members who have a legitimate educational interest in the information. If you have questions regarding the completion of this form, please contact the school health office.

**Parent/Guardian Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

Schumann Elementary Health Office - Katie Bucka, CNP, LSN  
 Orono Intermediate School Health Office - Jennifer Fossen  
 Orono Middle School Health Office - Kelly Leary, RN, LSN  
 Orono High School Health Office - Ann Turner  
 Janet Franzen, MSN, RN, LSN, District Nurse

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