

ANNUAL STUDENT HEALTH UPDATE FORM

Student Name (First Last) _____ **Birthdate** ____ / ____ / ____
Gender: M ; F **School** _____ **Grade** _____ **Student ID** _____ **Teacher** _____

Dear Parent/Guardian: **A student's health may affect his/her learning. Therefore, health information is important in planning for the student's needs at school.** Health information from this form may be shared with other school staff as needed. Please, complete this form and return it to the school health office as soon as possible.

➔ ☐ **My child has NO HEALTH CONCERNS** ← or check any current health conditions:

If you checked any of these conditions or if your child has a condition that might result in an emergency, **CALL THE SCHOOL NURSE BEFORE the beginning of school.**

The school needs an emergency action plan from your child's provider.



☐ **Life Threatening Allergy/Anaphylaxis (Epinephrine prescribed); Allergen(s)** _____

☐ **Seizures/Epilepsy:** Emergency Medication: ☐ Yes ☐ No

☐ **Type 1 Diabetes;** ☐ insulin pen; ☐ pump;

☐ CGM(sensor) ☐ **Type 2 -** ☐ takes medication

☐ **Asthma – SEVERE**

☐ Other life-threatening condition _____

Food Intolerance/Sensitivity: _____

Reaction: _____

➔ **Per MN State law, substitutions can be made only with a provider's statement verifying the allergy/intolerance** ←

☐ ADHD - diagnosis date and clinic _____

☐ Autism Spectrum Disorder

☐ Hearing Aids

☐ Vision: Glasses Contacts

☐ Neurological/brain _____

☐ Mental Health Concerns (i.e. anxiety, depression)

_____ ☐ takes medication

☐ Heart or blood condition (sickle cell disease, hemophilia, on blood thinners) _____

☐ Activity restrictions/special equipment (wheelchair, braces) _____

☐ Other health needs (Tube Feeding, Catheterization, Visual Impairment, Kidney, Central Line, Private Duty Nurse, etc.) _____

Does your child have any disabilities, physical limitations, developmental delays, or sensory concerns? Yes or No

If YES, please explain: _____

MEDICATIONS

☐ My student requires medication at school for the current school year



IF YOU CHECKED THIS BOX, CONTACT THE SCHOOL NURSE

My student takes medication at home: medication name (s) _____

☐ daily ☐ as needed

No medications, prescription or over the counter, are given to a student unless prescribed by the child's health care provider and supplied 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.

Health Care Provider & Clinic Name _____

Health Care Specialist/Clinic (endocrine, neurology, behavioral, orthopedic, etc.) _____

Consent to share immunization information

I agree to allow school personnel to share my student's immunization record with Minnesota's Immunization Registry. This is voluntary consent. All information is considered private data and can only be released with authorization.

☐ I do authorize

☐ I do not authorize

*****PLEASE, PROVIDE A COMPLETE RECORD OF YOUR CHILD IMMUNIZATIONS UPON ENTRANCE TO PRESCHOOL, KINDERGARTEN, GRADE 7, GRADE 12, AND FOR STUDENTS NEW TO THE DISTRICT, OR WHO RECEIVED IMMUNIZATIONS IN ANOTHER STATE OR COUNTRY*****

Please confirm updated phone numbers are on file for you and emergency contacts so we can reach you in case of illness or emergency

➔ **Parent/Guardian Signature** _____ **Date** _____ ←

FOR OFFICE USE ONLY : initials date
NEEDS LSN REVIEW ☐ _____
ENTERED IN SKYWARD ☐ _____

5/28/25