



HAYFIELD COMMUNITY SCHOOLS
Health Services
Annual Health Information

**Please return this
form to the
School Health Office**

Student Name: _____ **Birth Date** _____ **Grade** _____
First Middle Last

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. Health information from this form may be shared with other school staff as needed. Please complete this form and return it to school as soon as possible.

HEALTH CONCERNS

Please ☒ if your child has any of these health concerns:

☐ **No Health Concerns**

☐ Asthma or other breathing problems

a. Has your child ever been diagnosed by a **doctor** as having asthma? ☐ Yes ☐ No

b. Has your child had episode(s) of wheezing (whistling in the chest) in the last 12 months? ☐ Yes ☐ No

c. In the last **12 months** have you heard your child wheeze or cough after active playing? ☐ Yes ☐ No

d. Other breathing problem

☐ A.D.H.D./A.D.D.

☐ **Allergies:**

☐ Bladder or Bowel problems:

☐ Diabetes

☐ Heart Problems:

☐ Activity restrictions:

☐ Any recent surgeries or hospitalizations? _____ Yes _____ No

☐ Pregnancy? ☐ Due date:

☐ Seizure Disorder:

☐ Social/emotional/mental health:

☐ Other health concern or significant history of problems:

If yes, explain:

Describe any issue checked above:

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

If yes, describe:

MEDICATIONS: List **all** medications that your child takes every day or as needed (home or at school).

Medication Name	Purpose	Dose	How often taken?
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Our district requires doctor orders and parent permission for ANY medication(s) that need to be taken at school.

Forms available on website (District → School Nurse → Forms) or in the health office.

Please Turn Over and Complete Back Side ➡

Vision

- ☐ **No vision problem**
- ☐ Glasses/contacts prescribed
- ☐ Wears glasses/contacts all the time
- ☐ Wears glasses in classroom only
- ☐ Glasses lost/broken
- ☐ Has (or has had) glasses but does not wear
- ☐ Other (describe) _____

Hearing

- ☐ **No hearing problem**
- ☐ Frequent ear infections (more than 3 per year in past year)
- ☐ Has ear tube(s) Date inserted _____
- ☐ Hearing loss right ear left ear
- ☐ Hearing aid(s) right ear left ear
- ☐ Aids lost/broken
- ☐ Has (or has had) aids but does not wear
- ☐ Other (describe) _____

Comments: Use this space to describe problems listed.

HEALTH INSURANCE:

- ☐ My child has health insurance:
- ☐ Medical Assistance ☐ Minnesota Care ☐ Other (for example through work)
- ☐ My child has no *health* insurance. ☐ My child has no *dental* coverage. ☐ My child has no *vision/eye* coverage.

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 and Phone	Approximate Date of Last Exam
Primary Provider (regular doctor)		
Eye Specialist		
Ear Specialist		
Other Specialist		

Hospital preference if transport is needed (circle one): St. Mary's-Rochester OMC-Rochester Mayo-Austin

This health information may be shared with Hayfield/Brownsdale school staff and Dietary/Bus service as needed. If you do not want this health information shared, please contact the school nurse in writing. Michele Nelson, at 477-3235 x 283 or nelsomi@hayfield.k12.mn.us.

Parent/Guardian Name: _____ Date: _____

How to reach you if your child is sick or injured: _____ (work/cell) _____ (work/cell)

If you can't be reached (phone #/who): _____