

MINNESOTA STATE ACADEMIES STUDENT HEALTH INFORMATION

Student's Name	Sex	Birthdate	Grade
Parent/Guardian Name		E-Mail address	
Preferred mode of contact: Text ____ E-mail ____ Phone ____			
Parent/Guardian #1 Cell:		Parent/Guardian #2	Other (home/work etc.):
Address:			
Emergency Numbers - List in order you wish us to call:			
Name	Relationship	Telephone Number	
Name	Relationship	Telephone Number	
Name	Relationship	Telephone Number	
PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD			
*Insurance Company Name & Policy Number			
*Medical Assistance? No ____ Yes ____ (Please include MA Number - 8 digits)			
Does your child take daily medication? No ____ Yes ____ If yes, is daily medication/emergency medication to be given while at school/dorm? No ____ Yes ____ (Need Med Orders)			
Regular Diet ____ OR Special Diet ____ (ie: gluten free, lactose free, pureed, bite size, food allergy, tube feeding, etc) If Special Diet needed, please explain: DOCTOR ORDERS REQUIRED FOR SPECIAL DIETS & ALL MEDICATIONS INCLUDING OVER-THE-COUNTER MEDS			
Does your child have any food, medication or insect allergies? No ____ Yes ____ If yes, please list allergy & reaction...			
Have there been any changes or any current concerns in your child's health? No ____ Yes ____ If yes, please explain...			
Does the student have a physical condition which limits his/her participation in classroom activity, physical education, or sports? If yes, please describe:			
HEALTH AUTHORIZATION AGREEMENT			
The undersigned, hereby grant permission for school based nursing health care. I understand routine treatment or preventative measures will be provided by the health staff of the Minnesota State Academies without cost to child's parent or legal guardian. The cost of treatment, which requires local physician services, hospitalization or other services beyond the Academies' ability to provide, such as x-rays, laboratory tests, and dental work, will be assumed by the parent / legal guardian. In case of serious injury or sudden illness, I understand the Academies Personnel will attempt to get in touch with me immediately, however, I grant permission for the Superintendent, Health Services Staff or their representative to arrange for whatever immediate care is required for the health and safety of my child. I understand I am responsible for the payment of any medical or hospital service provided. If my child receives related services, personal care services (PCA) during the school day – I authorize the licensed school nurse to provide nursing evaluation for my child as needed during the school year for the purpose of determining my child's health care needs in the school setting.			
Signature of Parent or Legal Guardian		Date	