

	Minnesota State Academies		STUDENT ENROLLMENT HEALTH AGREEMENT AND PHYSICIANS EVALUATION REPORT	ED-00181-11
	For the Blind 400 SE 6 th Ave. P.O. Box 68 Faribault, MN 55021	For the Deaf 615 Olof Hanson Drive P.O. Box 308 Faribault, MN 55021-0308		

GENERAL INFORMATION AND INSTRUCTIONS: PLEASE THOROUGHLY READ THE FOLLOWING MEDICAL AGREEMENT SECTIONS AND RESPOND WITH THE REQUESTED INFORMATION. This form will remain on file at the Minnesota State Academies. This information will be used for the administration of appropriate care and medically related services and may be released to hospital, medical and health personnel. You are not legally required to supply such information; however, refusal to do so may result in your child not being allowed to attend the Minnesota State Academy for the Deaf/Minnesota State Academy for the Blind. Except as provided above, only authorized school personnel and other persons authorized under the FERPA of 1974, the Minnesota Government Data Practices Act (Minn. Statute 15.1611, et seq.), and Minn. Statute 123.70 and 144.29 will be permitted access to this information without parental consent.

STUDENT IDENTIFICATION INFORMATION			
Student's Name	Sex	Birthdate	Social Security Number
Parent/Guardian Name	E-Mail address		
Home Telephone:	Mom's Work #:	Dad's Work #:	
	Cell #	Cell #	
Emergency Numbers - List in order you wish us to call:			
Name	Relationship	Telephone Number	
Name	Relationship	Telephone Number	
Name	Relationship	Telephone Number	
*Insurance Company Name & Policy Number			
*Medical Assistance Number			

***NOTE: WE NEED A COPY OF BOTH SIDES OF INSURANCE AND M.A. CARDS**
– Also a vision and hearing screening is required for all new students. Please include reports.

HEALTH AUTHORIZATION AGREEMENT
The undersigned, hereby grant permission for necessary routine 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 undersigned. 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 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. In the event of an exposure incident with my child and a staff member involving blood or other body fluids, I grant permission to allow blood testing to determine my child's bloodborne pathogen status.
Signature of Parent or Legal Guardian Date

STUDENT ENROLLMENT HEALTH AGREEMENT AND PHYSICIANS EVALUATION REPORT (CONTINUED)

Student Name: _____

This questionnaire is designed to help the physician develop a comprehensive health record and evaluation on your child for health care personnel at the Minnesota State Academies. Parent please completed this page of the questionnaire before your physician sees your child.

FAMILY HEALTH HISTORY (BIOLOGIC FAMILY)

Circle conditions that have occurred in the child's immediate family, grandparents, aunts, uncles and first cousins and describe below.

Anemia	Arthritis	Asthma	Birth Defect
Bleeding	Blindness	Deafness	Drug Allergy
Eczema	Hay Fever	Heart Disease	High Blood Pressure
Kidney Failure	Diabetes	Developmental Delay	Seizure Disorder

Comments: _____

STUDENT HEALTH HISTORY

- Problems mother had with pregnancy: _____
- Delivery complications: _____
- Birth Weight: _____
- Developmental Milestones (age at which skill was accomplished)

Sat alone: _____	First words: _____	Tied shoes: _____
Walked: _____	Toilet trained: _____	Rode bike: _____
Onset of vision and/or hearing loss: _____ Cause: _____		
Glasses _____	Hearing Aide: _____	
- Has child had chicken pox? _____
- Please circle problems that apply to student:

Behavior Problems	Heart Disease	Sleep Disturbance	Bleeding Tendency	Hepatitis
Tonsillitis	Diabetes	Hyperactivity	Tuberculosis	Ear Infections
Kidney Disease	Urine Infection	Rheumatic Fever	Seizures	Depression
Menstrual irregularity		Enuresis (bed wetting)		
- Operations and/or accidents: _____

8. Has child had a comprehensive evaluation by a health center? No Yes If yes, specify when and where.
- _____