

Student: _____ Grade: _____ Gender: _____ Birthdate: ___/___/___
Last First MI

Primary Address: _____ Phone: _____

Dear Parent/Guardian:

A student's health may affect his or her learning. Therefore, updated health information is important. The following information will be held in confidence and disclosed to school personnel to the extent necessary to protect the health and safety of the student. This form should be completed each school year. Please complete this form and return it to the school Health Office as soon as possible.

Thank you

ISD 622 Health Services

HEALTH INFORMATION

Health Concerns

Please put a ✓ if the student CURRENTLY HAS or HAS HAD IN THE PAST any of these health concerns:

No Health Concerns

Allergies (if yes, to what): _____

Anaphylactic/Life threatening? **Yes** *Needs care plan **No**

Asthma or breathing problems (if yes, see below):

• Has the student had episode(s) of wheezing in the last 12 months? **Yes** *Needs care plan **No**

• Has the student had to take medication to resolve breathing problems in the last 12 months? **Yes** *Needs care plan **No**

Bladder/Bowel problems (if yes, describe): _____

Diabetes (if yes, see below): *Needs care plan

• Type (I or II): _____

• Managed by: Diet only Oral medication Insulin injections Insulin pump

Diagnosed diet restrictions/needs (if yes, describe): _____

Heart problems (if yes, describe): _____

Seizures (if yes, see below): *Needs care plan

• Type (describe) _____ Date of last seizure: _____

Social/Emotional/Mental Health concerns (if yes, describe): _____

Recent surgeries or hospitalizations (if yes, describe): _____

Activity restrictions (if yes, describe): _____

***Note:** If yes, a current written note from your provider stating the restrictions and length of restrictions is needed in the health office

Autism

Genetic/Congenital disorder

Hearing impaired

Blood disease

Vision impaired

Migraines

Cancer

Head injury/Concussion

Other: _____

Complete for High School Students Grades 9-12

According to MS 121.222 (2005) a secondary student may possess and use non-prescription pain relief such as Tylenol or Motrin. Medications must remain in the original container and taken according to directions. Parent/Guardian permission must be given in order for students to "self-carry" non-prescription pain relievers.

I hereby give my child permission to "self-carry" non-prescription pain relievers.

Signature: _____

Parent(s)/Guardian(s) Note: The school district does not supply over-the-counter pain relievers to students.

Health Insurance

The student HAS health insurance

The student DOES NOT HAVE health insurance. Would you like assistance with applying? Yes No

Health Care Providers

Primary Care Provider	Clinic/Location	Phone Number

Hospital Preference	Address	Phone Number

***Note:** In case of an emergency, our procedure will be to attempt to contact the parent/guardian. Paramedics or local police may be called for assistance. Your student will be taken to the most appropriate hospital for emergency care if no other arrangements have been made.

Emergency Contacts

Parent/Guardian 1: _____
 Print Name Primary Phone Number Work Phone Number

 Email Address

Parent/Guardian 2: _____
 Print Name Primary Phone Number Work Phone Number

 Email Address

Emergency Contact: _____
 Print Name Relationship Phone Number

Emergency Contact: _____
 Print Name Relationship Phone Number

Custody Issue Yes No

***Note:** If custodial issues are involved, a copy of decree must be on file at school.

This information is current and correct. I understand that it is my responsibility as the parent/guardian to notify the school of new or existing health concerns or any changes to contact information. I understand that this health history form must be updated every school year.

Parent/Guardian Signature

Printed Name

Date