SCHOOL HEALTH OFFICE

STUDENT HEALTH FORM

2024-2025

Student's Name _______________________________ Birthdate ___ / ___ / ___ Gender ____ Grade (2024-25) _____

Dear Parent/Guardian: *The American Academy of Pediatrics recommends children receive a physical examination annually. Health information is vital in planning and supporting students while attending school. Please provide us with current health information each school year. State Law (M.S. 123.70 & M.S. 144.29) requires your child be immunized & receive a comprehensive physical examination before entering Kindergarten or elementary school.*

HEALTH CONCERNS: Please **X** if the student has any of the following and ****submit an emergency action plan*** *for starred conditions.*

_____ **NO HEALTH CONCERNS**

_____ **Allergies*** to ________________________________; reaction____

Caused by (circle): Ingestion (eating allergen) Contact (touching allergen) Airborne (breathing allergen)

Medication (epinephrine) will be submitted to be used, as needed, in school (circle): Yes No

_____ Food Intolerance to ________________________________; reaction____

_____ **Asthma*** ____

Caused by (circle): Exercise Irritants (smoke, fragrances, etc) Allergens (pollen, mold, dander, etc)

Medication (albuterol) will be submitted to be used, as needed, in school (circle): Yes No

_____ **Diabetes*** (circle): Type Type 2 Managed by (circle): Diet/Activity Oral medication Insulin injections Pump

_____ **Seizures*** type/description/frequency ____

_____ Behavioral/Mental Health Concern ____

_____ Recent Surgery/Restrictions ____

_____ Other Health Concern ____

Clinic and Doctor ____

Health Insurance ____

Preferred Hospital in the event of an emergency ____

MEDICATIONS: Complete a Medication Administration Form for ***any*** medication (both prescription and non-prescription) needing to be administered during school hours (forms available upon request). WRITTEN CONSENT IS REQUIRED BY BOTH THE STUDENT'S GUARDIAN AS WELL AS THEIR HEALTH CARE PROVIDER prior to administering any medication in school.

CONSENT: *I attest to the information provided. I acknowledge that it is my responsibility to inform the school of any changes to the health status of this student including health conditions, needs, medications, and/or allergies. I understand and agree that this student may receive a routine screening for vision and hearing deficiencies. I will comply with all school illness, immunization, and medication policies. I give my consent for any treatment deemed necessary in an emergency and, if necessary, the transfer of the student by Emergency Medical Services. The contacts listed below have my permission to pick-up the student if I am unavailable. Furthermore, I give permission for school health staff to confidentially exchange health information - both within the school as well as with outside health care providers - for use in meeting this student's health and educational needs in school.*

Parent/Guardian Printed Name	Parent/Guardian Signature	Date

Phone Number(s)	Email
Emergency Contact 1 Name	**Phone Number**
Emergency Contact 2 Name	**Phone Number**