Please return this form to the School Health Office

Student Health Information

Student Name: _____ Birth Date _____ Boy ☐ Girl ☐
Last First Middle

Grade/Teacher_____

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 the school health office as soon as possible.

HEALTH CONCERNS

Please ✓ and explain if your child has any of the following:

☐ ***No Health concerns***

☐ Attention Deficit Hyper-activity Disorder/Attention Deficit Disorder (ADHD/ADD)

☐ Allergies (to what: foods, medication, environmental?): _____

- Is the allergy life-threatening (needs an epipen available)? Yes No

☐ Asthma or other breathing problems:

Has your child ever been diagnosed by a Healthcare Provider as having asthma? Yes No

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

In the past 12 months have you heard your child wheeze or cough after active play? Yes No

Other breathing problem (describe):_____

☐ Bladder problems/Bowel problems (describe):_____

☐ Diabetes: ❒ Type 1 ❒ Type 2 Managed by: ❒ Diet only ❒Oral meds ❒ Insulin injections ❒ Insulin Pump

☐ Heart/Blood Problems (describe): _____

☐ Seizures: Type _____ Date of last seizure: _____

☐ Social/emotional/behavioral/mental health concerns (describe): _____

☐ Other health concern or significant history of problems (describe):_____

☐ Activity restrictions (describe): _____ _____

☐ Recent surgeries or hospitalizations (describe):_____

☐ Has your child ever been diagnosed with a concussion (month/year):_____

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

If yes, describe: _____

MEDICATIONS

First, list ALL medications that your child takes:_____

Now, list **ALL** medications that your child needs DURING THE SCHOOL DAY. An authorization with parent and health care provider consent is required each school year for all the following listed prescription AND over-the-counter medications: _____

PLEASE TURN OVER AND COMPLETE BACK SIDE

Vision

☐ Glasses/contacts prescribed
☐ Wears glasses/contacts all of the time
☐ Wears glasses in classroom only
☐ No vision problem

Hearing

☐ Frequent ear infections (more than 3 per year in past year)
☐ Has ear tube(s)
☐ Hearing loss ☐ right ear ☐ left ear
☐ Hearing aid(s) ☐ right ear ☐ left ear
☐ No hearing problem

Comments: (Use this space to describe problems listed.)

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 Health Provider (regular doctor)		
Dental Provider		
Other Specialist (specify type):		

Hospital preference: _____

This health information may be shared with SCPA school staff as needed. If you do not want this health information shared, please contact the school nurse at nurse@stcroixprep.org or 651-395-5906.

Parent/Guardian signature _____ Daytime phone _____

Print Parent/Guardian name: _____ Date: _____

Parent/Guardian e-mail contact: _____