**Grade ______**

# Edina Public Schools• Annual Health Information 2014-2015

**Please complete both pages of this two page form. Return to the school health office when completed.**

**Student Name:**________________________________________________**Gender** ________________
Last First Middle Initial

**Birth Date**__________________ **School** ______________________________________________

**Street Address** _____________________**City**___________ **Zip**_________ **Home Phone**______________

**Parent Name** ________________________ **Address** ______________________________________
If different from student
**Phone #1**____________________**Phone #2**______________________**Phone #3** __________________

**Parent Name**_________________________**Address** ______________________________________
If different from student
**Phone #1** ___________________**Phone #2**_________________ **Phone #3**______________________

**Parent / Guardian email contact:** ____________________________

**EMERGENCY NAMES** (*Persons authorized to care for student when ill and/or act in an emergency when parents cannot be reached.)*

**Name # 1** ______________________**Phone #1**_______________ **Phone #2**_________________

**Name # 2** ______________________**Phone #**1 _______________**Phone #2** _________________

Health information from this form assists with planning for your child's needs at school. Please complete this 2 page form and return it to school as soon as possible.

**PHYSICIAN**__________________________________________**Phone**_______________________

**DENTIST** ___________________________________________**Phone**_______________________

**HOSPITAL** (*for emergency*) _____________________________________________________________

**HEALTH CONCERNS** **Please check all that apply.**

- ❑ **Identified Health Concerns**
  - ❑ ADHD / ADD / Other learning disabilities
  - ❑ Allergies (list) ________________________________________________
  - ❑ Asthma or other breathing problems
  - ❑ Bladder problems / Bowel problems (describe) ________________________________
  - ❑ Chickenpox (List month and year he / she had disease) __________________________
  - ❑ Diabetes: ____ Type 1 ____ Type 2 Managed by: ☐ Diet only ☐ Oral meds ☐ Insulin injections ☐ Insulin pump
  - ❑ Food intolerance (describe)_____________________________________________
  - ❑ Heart problems (describe) ______________________________________________
  - ❑ Seizures: Type (describe)____________________________Date of last seizure:____________
  - ❑ Social / Emotional / Behavioral / Mental health concerns (describe) ______________________
  - ❑ Anxiety disorder
  - ❑ Depression
  - ❑ Vision deficit that requires preferential seating
  - ❑ Hearing deficit that requires preferential seating
  - ❑ Other health concern or significant history of problems (describe) _______________________
  - ❑ Activity restrictions: (describe) ____________________________________________
- ❑ **Surgeries or hospitalizations in the last year. Explain.**_________________________________
- ❑ **No Health Concerns**

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**Please Turn Over and Complete Page Two**

**EMERGENCIES:** Does your child have a health problem that could result in an emergency? ☐☐ Yes ☐ No
If yes, describe: ______________________________________________

______________________________________________

______________________________________________

**MEDICATIONS TAKEN EVERY DAY OR WHEN NEEDED**
(This section does not serve as a medical order for medication administration.)

List **ALL** medications that your child takes.

| Medication Name | Reason | Dose | How often taken? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**If your child needs to take medication at school, please consider the following:**

1. The **Authorization for Administration of Medication form** is **REQUIRED** for all medication(s) taken at school, including non-prescription (over the counter) medications. Students must take all medications at school through the health office unless otherwise arranged individually with the licensed school nurse.

2. **The Authorization for Administration of Medication form must be signed by both the HEALTH CARE PROVIDER and PARENT. A new consent is needed each school year.**

3. Forms are available in the health office.

**Is there any other information that might be helpful for us to know about your child or circumstances at home that could affect him/her at school?**

______________________________________________

______________________________________________

______________________________________________

In order to provide for the health and safety of your child the above information may be shared with school staff working with this student and with Emergency Response Personnel in the event that 911 is called.

Parent / Guardian name: ______________________________________________
(Print Name)

Parent / Guardian Signature: ______________________________ Date ____________________
(month/day/year)

The school intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested personal information. There will be no consequences for not providing the information. It may result in an incomplete health and safety plan for your child.
The information you provide will be shared only with staff in the school district whose jobs require access to this information to ensure your child's safety and school success

(MS Section 13.04, Subdivision2)
4/19/2013