2024-2025 School Year
Student Health Information / Concerns

Student Name: _____ **Birth Date:** _____ **Gender:** _____ **Grade:** _____

Name/relationship of person completing this form: _____

MEDICATIONS

Please list all medications needed during the school day. An authorization with parent **and** health care provider consent is required each school year for all the following listed prescription medications. A new consent is needed each school year.

Medication Needed During the School Day: _____

_____

All medications taken outside of school: _____

_____

HEALTH CONCERNS: Please X and explain if your child has any of the following:

Yes	No	
☐	☐	Attention Deficit Hyper-Activity Disorder/Attention Deficit Disorder (Check One: ☐ ADHD ☐ ADD)
☐	☐	Life Threatening Allergies* (to what? _____)
☐	☐	Has the allergy been diagnosed by a doctor? Medication for allergy:_____ *Must provide anaphylaxis action plan provided by healthcare provider
☐	☐	Asthma **If yes, does your student require medication for their asthma?** ☐ Yes ☐ No *Must provide asthma action plan from healthcare provider
☐	☐	Other Breathing Problems-please describe: _____
☐	☐	Diabetes ☐ Type 1 ☐ Type 2 Medication: ☐ Insulin Pen ☐ Insulin Pump ☐ Oral Medication ***Must provide diabetes management plan from healthcare provider
☐	☐	Heart Condition: Describe in detail: _____
☐	☐	Seizure Disorder: Type of seizures and date of last seizure: _____ *Must provide seizure action plan from healthcare provider
☐	☐	History of concussion and/or head injury? Please describe: _____
☐	☐	Mental health diagnoses? (anxiety, depression, bipolar, suicide attempt, suicidal ideation, etc) Please Indicate: _____
☐	☐	Hearing Difficulties? ☐ Ear Tubes ☐ Hearing Aids ☐ Left ☐ Right
☐	☐	Vision Difficulties? ☐ Glasses/Contacts ☐ Classroom Only ☐ Reading Only ☐ Full Time
☐	☐	Recent Surgeries/Hospitalizations? Please describe: _____
☐	☐	Activity Restrictions? Please describe: _____
☐	☐	Target of /Instigator of bullying (Circle one)
☐	☐	Other: Please Indicate: _____
☐	☐	Receives Special Education IEP/504 Services
☐	☐	My child has health insurance.
☐	☐	I need assistance finding health insurance.

I attest to the information provided and give permission for its release for confidential use in meeting my child's health and educational needs in school. 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, and/or allergies.

Parent/Guardian signature _____ Date: _____

Relationship to student: _____

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 information—there will be no consequences—it may result in an incomplete health and safety plan for your child. The information you provide will only be shared with those whose jobs require access to this information to ensure your child's safety and school success. (MS section 13.04, Subdivision 2)

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