

HEALTH INFORMATION (2018-2019)

Health or Disability Concerns: Please indicate if your child has any of these concerns and explain: NO HEALTH CONCERNS	tudent Name: Date of Birth:				
Chescribe reaction		se indicate if your	child has any of these co	ncerns and explain:	
Medication (see below) Does not take medication Diabetes: Type 1 Type 2 Insulin Injections Insulin Pump Medication Medication Meart Problem (describe) Medication Meart Problem (describe) Medication	□Allergic Reactions to be aware of at	school (to what?) _			
Attention Disorder: ADD ADHD Medication (see below) Does not take medication Medication (see below) Does not take medication Medication (see below) Does not take medication Diabetes: Type 1 Type 2 Insulin Injections Insulin Pump Heart Problem (describe) Mearing Loss: right ear Ileft ear Ilef	(Describe reaction)				
Medication (see below) Does not take medication Diabetes: Type 1 Type 2 Insulin Injections Insulin Pump Heart Problem (describe) Hearing Loss: right ear left ear Hearing Aids: right ear left ear Vision: Wears glasses /contacts wears in classroom only Neurological Seizures: Type: Date of last seizure: Recent surgery or hospitalization: Explain Mental Health concerns: Other health concerns or additional health information: Emergencies: Does your child have a health concern that could result in an emergency? YES NO If yes, please describe: Medications: List ALL medications that your child takes every day or when needed. * Consent forms are required year for ALL medications administered at school. Please see attached forms. Name of Medication Purpose Dose How Often Taken Dose How Often Taken Dose Dose How Often Taken Dose Dose	□Medication (see below)	□Does not take	medication		
Asthma Known Triggers:	□Attention Disorder: □ADD □ADHD				
Medication (see below) Does not take medication Diabetes: Type 1 Type 2 Insulin Injections Insulin Pump Heart Problem (describe) Hearing Loss: right ear Hearing Aids: right ear left ear Vision: Wears glasses /contacts wears in classroom only Neurological Seizures: Type: Date of last seizure: Recent surgery or hospitalization: Explain Mental Health concerns Other health concerns or additional health information: Emergencies: Does your child have a health concern that could result in an emergency? YES NO If yes, please describe: Medications: List ALL medications that your child takes every day or when needed. * Consent forms are required year for ALL medications administered at school. Please see attached forms. Name of Medication Purpose Dose How Often Taken Dose Dose How Often Taken Dose Dose How Often Taken Dose Dose	□Medication (see below)	□Does not take	medication		
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Heart Problem (describe)	□Medication (see below)	□Does not take	medication		
Hearing Loss: right ear left ear Hearing Aids: right ear left ear Vision: Wears glasses / contacts wears in classroom only Neurological Seizures: Type: Date of last seizure: Date of last seizure:	□Diabetes: □Type 1 □Type 2 □Insuli	n Injections □Insulir	n Pump		
□ Vision: □ Wears glasses /contacts □ wears in classroom only □ Neurological □ Date of last seizure: □ Seizures: Type: □ Recent surgery or hospitalization: Explain □ Mental Health concerns: □ Other health concerns or additional health information: □ Cother health concerns or additional health information: □ Other health concerns or additional health concern that could result in an emergency? □ YES □ NO If yes, please describe: ■ Medications: List ALL medications that your child takes every day or when needed. * Consent forms are required year for ALL medications administered at school. Please see attached forms. Name of Medication Purpose Dose How Often Taken ■ Name of Medication is helpful in establishing a comprehensive picture of the student's health and safety needs while school. The information on this form is considered confidential and will remain in the student's health file located in the	□Heart Problem (describe)				
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Recent surgery or hospitalization: Explain Mental Health concerns: Other health concerns or additional health information: Emergencies: Does your child have a health concern that could result in an emergency? Wedications: List ALL medications that your child takes every day or when needed. * Consent forms are required year for ALL medications administered at school. Please see attached forms. Name of Medication Purpose Dose How Often Taken The above information is helpful in establishing a comprehensive picture of the student's health and safety needs while school. The information on this form is considered confidential and will remain in the student's health file located in the	□Neurological				
□ Other health concerns or additional health information: □ □ Other health concerns or additional health information: □ □ Emergencies: Does your child have a health concern that could result in an emergency? □YES □NO If yes, please describe: □ ■ Medications: List ALL medications that your child takes every day or when needed. * Consent forms are required year for ALL medications administered at school. Please see attached forms. Name of Medication Purpose Dose How Often Taken □ □ Dose How Often Taken □ □ The above information is helpful in establishing a comprehensive picture of the student's health and safety needs while school. The information on this form is considered confidential and will remain in the student's health file located in the	□Seizures: Type:	Date of last seizure:			
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Emergencies: Does your child have a health concern that could result in an emergency? YES NO	□Mental Health concerns:				
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for ALL medications administered at school. Please see attached forms. Name of Medication	If yes, please describe:				
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Health Office. There will be no consequences for not providing the information, however it may result in an incomplete health and safety plan for the student. The information you provide will be shared only with staff in the school whose job require access to this information to ensure your student's safety and school success.	school. The information on this form is Health Office. There will be no consec health and safety plan for the student.	s considered confidences for not provents. The information yo	ential and will remain in the viding the information, hower ou provide will be shared on	student's health file located in the ever it may result in an incomplete ly with staff in the school whose jobs	
Parent/Guardian Signature Date	Parent/Guardian Signature		Date		
Phone: 952-918-1845 Fax: 952-918-1801 Email: healthoffice@ism-sabis.net	Phone: 952-918-184	5 Fax: 952-91	8-1801 Email: health	noffice@ism-sabis.net	