



### HEALTH INFORMATION (2018-2019)

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Health or Disability Concerns: Please indicate if your child has any of these concerns and explain:**

☐ **NO HEALTH CONCERNS**

☐ Allergic Reactions to be aware of at school (to what?) \_\_\_\_\_

(Describe reaction) \_\_\_\_\_

☐ Medication (see below) ☐ Does not take medication

☐ Attention Disorder: ☐ ADD ☐ ADHD

☐ Medication (see below) ☐ Does not take medication

☐ Asthma Known Triggers: \_\_\_\_\_

☐ 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 yearly 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 at school. The information on this form is considered confidential and will remain in the student's health file located in the 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 jobs require access to this information to ensure your student's safety and school success.

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

Phone: 952-918-1845

Fax: 952-918-1801

Email: [healthoffice@ism-sabis.net](mailto:healthoffice@ism-sabis.net)