Sleepy Eye Public Schools
Health Information Form
Pre-K – 12th Grade

Please return this form to School Health Office

Student Name _____ **Birth Date** _____
First Middle Last

School Year _____ **Grade/Teacher** _____ **Male** ☐ **Female** ☐

Dear Parent/Guardian:

A student's health may affect his or her learning. Therefore, health information is important in planning for the student's needs at our school. Health information from this form may be shared with other school staff only as needed for student safety and health needs to be met. Please complete this form fully and return it to school as soon as possible.

Health Concerns

Please put a √ if the student has any of these health concerns:

☐ ***No Health Concerns***

☐ ADHD/ADD

☐ Allergies (to what?) _____

☐ Asthma or other breathing problems

a. Has student ever been diagnosed by a **doctor/primary provider** as having asthma? ☐ Yes ☐ No

b. Has the student had episode(s) of wheezing (whistling in the chest) in the last 12 months? ☐ Yes ☐ No

c. In the last 12 months have you heard the student wheeze or cough after active playing? ☐ Yes ☐ No

d. Other breathing problems (please describe) _____

☐ Bladder and/or Bowel Problems (describe) _____

☐ Diabetes: ___Type 1 ___Type 2 Managed by: ☐ Diet ☐ Oral Meds ☐ Injectable Meds ☐ Insulin injections ☐ Insulin pump

☐ Exposure to drugs and/or alcohol before birth _____

☐ Heart Problems (describes) _____

☐ Is the student pregnant? (Due Date, complications, other children) _____

☐ Seizures: Type (describe) _____ Date of last seizure: _____

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

_____

In a form of therapy (describe) _____ On medications (list names): _____

☐ Recent Hospitalizations or Surgeries? (Date and describe) _____

EMERGENCIES: Does the student have a health problem that could result in an emergency? ☐ Yes ☐ No

If yes, describe: _____

PLEASE TURN OVER AND COMPLETE BACK SIDE ➡

Vision

- ☐ No Vision Problems
- ☐ Glasses/Contacts prescribed
- ☐ Wears glasses in class only
- ☐ Glasses broken/lost
- ☐ Had glasses but don't wear them
- ☐ Other (describe) _____

Hearing

- ☐ No Hearing Problems
- ☐ Frequent ear infections (more than 3 in the past year)
- ☐ Has tube(s) in ear(s): Date inserted_____Which ear(s) _____
- ☐ Hearing loss: _____right ear _____left ear
- ☐ Hearing aids: _____right ear _____left ear _____Aids Lost/broken
- ☐ Other (describe): _____

Comments: _____

MEDICATIONS: List **ALL** medications that the student takes every day or when needed. A **CONSENT FORM IS REQUIRED** for **ALL** medications prescribed or over the counter to be given here at school. *A new consent must be completed each school year.*

Medication Authorization Forms are available in Elementary and High School Offices.

Medication Name **Purpose** **Dose** **How often is it taken?**

_____

_____

_____

_____

Health Insurance:

Does the student have health insurance? _____ No the student does not have health insurance_____

Type: _____Medical Assistance _____Minnesota Care _____Private Insurance

Health Care Providers:

Does the student have a primary care/doctor or clinic where they usually go for health care? _____

Name of Doctor or Clinic Location & Phone

_____

_____

EMERGENCY CONTACTS: Who can we call in case of medical emergencies, especially if parent or guardian cannot be reached?

Name Relationship Cell phone Work phone Address

_____

_____

_____

_____

This health information may be shared with Sleepy Eye Staff if necessary. If you do not want this health information shared, please contact the school health office at **507-794-7903 Ext: 1412.**

Print Parent/Guardian: Parent/Guardian Signature Date

Parent/Guardian: Phone Number Email