Sleepy Eye Public School -HEALTH OFFICE INFORMATION

Student Name_____Birthdate_____Grade_____
Last Name, First Name

Please fill out **COMPLETELY- this information is important for the nurse's office to be aware of to better care for your student during the school day.**

This information will be used to update your child's health record and will be shared with school staff to assist with your child's health needs in school.

My Student has these health concerns: (please check ALL that apply to the above named student)

_____Diabetes _____Allergies/Food ____Asthma -- *Must Fill out Asthma form on back

_____Seizures _____Hearing Problems ____ADHD/ADD

_____ Mental Health _____ Physical Disabilities

_____ Vision Impairments(NOT correctable with lenses) **_____OTHER (specify below)**

_____ Special Dietary needs-request form from Taher Food Service (x1421)- Physician is required to complete form.

Please explain, **in detail,** for all items checked above (continue on a separate sheet of paper if needed):

_____

_____

_____

_____

If your child doesn't have any health concerns- please circle ->"NO PROBLEMS"

Name of Family Physician_____Clinic_____

Clinic Phone Number_____

***List all Medications and time of day administered:**

_____

_____

_____

_____

***A School Health Services** form must be completed and signed by a physician if **any prescribed** medications need to be given during the regular school day. Medication will only be given **during these hours (8:00 a.m.-2:30 p.m.),** not before or after school. **A Doctor's note is needed for these medications too:** cough drops, cough syrup, tylenol, ibuprofen, motrin, medicated or OTC lotions and any over-the-counter medications.

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In the event of an injury or illness you will be notified. If the injury requires immediate attention, a parent/guardian will be notified and "911" will be called the student **will be transported** to the Sleepy Eye Medical Center.

Parent authorization (please read and sign below, if not signed the school will follow the procedure as stated on this health form)
If I am unable to be reached, the Sleepy Eye Medical Center is authorized to administer emergency treatment as needed. I also authorized the release and exchange of information between the physician and Sleepy Eye Public School regarding the listed diagnosis. (signature below is my authorization)

Parent/Guardian Signature _____ Date _____

IMPORTANT If your child becomes ill and we are unable to contact you **within reasonable time(30 minutes)** at the phone numbers and emergency contacts you provided, the authorities will be notified to find you. We will also contact authorities if **you do not come within 30 minutes, to pick up** your child when asked to, by the school nurse, or other authorized staff.

Health Information for Nurse's Office

Emergency Contact Information for Nurse's Office

These contacts will be used in case of emergency if we cannot reach a parent. These contacts are also authorized to pick up the student in a health emergency or illness, during or after school unless I have made other arrangements and notified the school. It is the legal parent/guardians responsibility to make sure the list is current and up-to-date if any changes should occur during the school year.

Name	Relationship	Home Phone	Work Phone	Cell Phone

ASTHMA INFORMATION FORM

(Complete this form if applies to your child)

Student Name_____Grade_____

Date of Birth_____Teacher's Name_____School Year_____

Physician_____ Physician's Phone_____

Parent Name (printed)_____

Parents Phone_____

How long has your child had asthma? _____

Do they take any medications?_____ Name of Medication_____

How often do they take these medications? _____

Rate the severity of your child's asthma (Circle one)

(0 =Not severe) 0 1 2 3 4 5 6 7 8 9 10 (10=Severe)

What triggers your child's asthma? Mark all that apply:
__Illness __Emotions ___Exercise __Weather __Foods __Fatigue
__Medications __Cigarette or other smoke __Seasonal allergies
__Other (please list) _____

Does your child take medication during the school day? ____YES ____NO
Does your child carry their own inhaler during the school day? ____YES ____NO
Has your child been hospitalized in the last year for their asthma? ____YES ____NO
How often does your child see the doctor for their asthma? _____

Parent Signature _____Date_____

2022-2023