

Vision

- No Vision Problems
- Glasses/Contacts prescribed
- Wears glasses in class only
- Glasses broken/lost
- Had glasses but doesn'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.* Consent 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? Yes No

Type: Medical Assistance Minnesota Care Private Insurance (please list): _____

Health Care Providers:

Does the student have a primary care/doctor or clinic where they usually go for health care? Yes No Name

of Doctor or Clinic	Location & Phone

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: _____