

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 _____