Perpich Arts High School—Health Services
Annual Student Health Information 2017-2018

Please return this form to the school health office

Student name ____Birthdate: _____________________________________

Male _____ Female ________ Grade:_____ School attended last year: ____

Dear parent/guardian:

Your student's health impacts his or her learning. Therefore, health information is important in planning for your student's health and safety needs at school. Health information from this form may be shared with other school staff as needed. Please complete, sign and return the **health forms** along with your acceptance packet.

Jessica Liepke, BSN, RN, PHN, LSN Office: 763-279-4193 Fax: 763-591-4747 (Attn: Health Office)

Health concerns

Please check if your child has any of these health concerns:

___ ADHD/ADD

___ **Allergies to:** ____

___ **History of severe reaction to food or insect sting (type/date):** ____

Anaphylaxis? Yes ____ No _____

___ ***Action plan must be included**

___ **Asthma or other breathing problems**

a. Has your student ever been diagnosed by a doctor as having asthma? Yes ____ No _____

b. Does your student take any medications for asthma? Yes____ No____

c. Has your student had episode(s) of wheezing (whistling in the chest) in the past 12 months?
Yes ____ No _____

d. In the past 12 months have you heard your student wheeze or cough after activity/exercise/exposure to hot/cold weather?
Yes ____ No_____

d. Other breathing problems (describe) ____

___ ***Action plan must be included**

___ Bladder or bowel problems (describe) ____

___ Chickenpox (year he/she had disease) ______________

___ **Diabetes (type and date of diagnosis)** ____

___ ***Action plan must be included**

___ Heart problems (describe) ____

Activity restrictions? (describe) ____

___ **History of severe headaches or migraine**

___ Is student pregnant? If yes, list due date ______________

Does student have child(ren)? If yes, list age(s) ______________

___ **Seizures/epilepsy (type and frequency)** ____

___ ***Seizure action plan must be included**

___ Social/emotional/mental health (describe) ____

___ Other health concern or significant history of problems (describe)

____

If you indicate that your student has any of the **bolded** health conditions above, a medical care plan is required. If prescription medications are listed on the medical plan, a separate prescription medicine authorization is not required.

Student name ______________________________________

Any recent surgeries or hospitalizations? _____ Yes _____ No
If yes, explain:

____

Emergencies

Does your student have a health problem that could result in an emergency?
____ Yes _____ No

If yes, describe: ____

Please list all school emergency medical/health care plans or individualized health plans for your child and provide a copy or copies.

____

____

Medications

List **all** medications that your student takes every day or when needed. Written consent is **required** for **all** medication taken at school, including over-the-counter medications. **Both health care provider and parent/guardian must sign the consent.**
A new consent is needed each school year. Updated consent will be required for any new medications, medication adjustments, discontinued medications etc. Medication Authorization forms will be available in the school health office, by fax or email.

Medication name	Purpose	Dose	How often taken?

Vision

____ No vision problem

____ Glasses/contacts prescribed

____ Wears glasses/contacts all the time

____ Wears glasses in classroom only

____ Glasses lost/broken

____ Has (or has had) glasses but does not wear

____ Other (describe) _____________________

Hearing

____ No hearing problem

____ History of frequent ear infections

____ Has ear tube(s) Date inserted _______

____ Hearing loss __ Right ear __ Left ear

____ Hearing aid(s) __ Right ear __ Left ear

____ Aids lost/broken

____ Has (or has had) aids but doesn't wear

____ Other (describe) _________________

Comments: Use this space to describe problems listed more fully:

Student name: ____

Health insurance

____ My child has health insurance:

____ Medical Assistance ____ Minnesota Care ____ Assured Care ____ Other (i.e. work-based)

____ My child has no health insurance. _____ I would like information regarding affordable health insurance.

Health care providers

Does your child have a doctor of clinic where he/she usually goes for health care? ____ Yes ____ No

Name of primary doctor/clinic	**Location and phone**	**Approximate date of last exam**

Name of eye specialist	**Location and phone**	**Approximate date of last exam**

Name of ear specialist	**Location and phone**	**Approximate date of last exam**

Name(s) of other specialists

____

____

Local health care provider for residential students

Doctor/clinic	Location and phone

Local person who will take your student for health care when parent/guardian cannot:

Name and phone: ____

Hospital preference: ____

*Does this person have legal authority to seek health care for your student if you are unable? ____ Yes ____ No

This health information may be shared with school staff as needed. If you do not want this health information shared, please contact the school nurse.

Parent/guardian signature: __________________________ Print parent/guardian name: ___________________________________

Daytime phone: ___________________________________Email address: ____

Communication preference: telephone_____ *or* email _____ (please check one)

Date: ______________________________________