



PERPICH

Annual Student Health Information 2026-2027 REQUIRED

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 at nurse@pcae.k12.mn.us or 763-279-4193

Student Legal Name _____
Last (legal) First (legal) Middle (legal)

Student Chosen Name _____
Last (chosen) First (chosen) Middle (chosen)

Date of Birth: (mm/dd/yyyy) _____

Sex Assigned at Birth *Required for MN State reporting*: (mark one) _____ Male _____ Female

Gender Identity:

- ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Non-Binary
☐ Write in other _____

Print parent/guardian name: _____

Parent/guardian signature: _____ Date: _____

Daytime phone: _____ Email address: _____

Communication preference (please check one): ☐ Telephone ☐ Email Texting OK? ☐ Yes ☐ No

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

- ADHD/ADD
- Allergies to (examples: seasonal, medications, etc.) _____
- Allergies (EpiPen / anaphylaxis risk only) **an action plan dated after July 1st is required.**
Allergy to : _____
- Asthma or breathing problems (describe) _____
(If yes to asthma, an action plan dated after July 1st is required.)
- a. Student has been diagnosed by a doctor with asthma? If yes when?

- b. Student prescribed and taking medications for asthma? Medication(s): _____
- c. Other breathing challenges (describe) _____
- Bladder or bowel challenges (describe) _____
- Chickenpox (year the student had the disease) When? _____
- Diabetes (describe): Type 1 or 2? When diagnosed _____
(If yes to diabetes, an action plan dated after July 1st is required)
- Heart problems (describe) _____
- Activity restrictions? (describe) _____
- Headaches, history of severe or migraines
- Pregnancy: Is the student pregnant? If yes, list due date _____

- Does the student have a child(ren)? If yes, list age(s)

- Seizures/Epilepsy (describe) _____

(If yes to Seizures, an action plan dated after July 1st is required)

- Student is diagnosed by a doctor with postural orthostatic tachycardia (POTs)? If yes when?

(If yes to POTs, an action plan dated after July 1st is required, if applicable)

- Social/emotional/mental health issues (describe)

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

Vision

No vision problem

Glasses/contacts prescribed

Wears glasses/contacts all the time

Other (describe)

Hearing

No hearing problem

Hearing loss ____ Right ear ____ Left ear

Hearing aid(s) ____ Right ear ____ Left ear

Other (describe)

Use this space to describe problems listed more fully: _____

Emergencies

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

If yes, describe: _____

Preferred hospital

Name: _____ Phone: _____

Location: _____

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

Name: _____ Phone: _____

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