# SCHOOL HEALTH OFFICE

## STUDENT HEALTH FORM

North Metro Flex Academy

**Student's Name** _____ **Birthdate** ___ / ___ / ___ **Gender** __ **Grade** ___ **School Year:** _____

**Dear Parent/Guardian**: *The American Academy of Pediatrics recommends children receive a physical examination annually. Health information is vital in planning and supporting students while attending school. Please provide us with current health information each school year. State Law (M.S. 123.70 & M.S. 144.29) requires your child be immunized & receive a comprehensive physical examination before entering Kindergarten or elementary school.*

**HEALTH CONCERNS:** Please **X** if the student has any of the following and ****submit an emergency action plan** *for starred conditions.*

_____ **NO HEALTH CONCERNS**

_____ **Allergies*** to _____; reaction_____

Caused by (circle): Ingestion (eating allergen) Contact (touching allergen) Airborne (breathing allergen)

Medication (epinephrine) will be submitted to be used, as needed, in school (circle): Yes No

_____ Food Intolerance to _____; reaction _____

_____ **Asthma*** _____

Caused by (circle): Exercise Irritants (smoke, fragrances, etc) Allergens (pollen, mold, dander, etc)

Medication (albuterol) will be submitted to be used, as needed, in school (circle): Yes No

_____ **Diabetes*** (circle): Type Type 2 Managed by (circle): Diet/Activity Oral medication Insulin injections Pump

_____ **Seizures*** type/description/frequency _____

_____ Behavioral/Mental Health Concern _____

_____ Recent Surgery/Restrictions _____

_____ Other Health Concern _____

Clinic and Doctor _____

Health Insurance _____

Preferred Hospital in the event of an emergency _____

**MEDICATIONS:** Complete a Medication Administration Form for ***any*** medication (both prescription and non-prescription) needing to be administered during school hours (forms available upon request). WRITTEN CONSENT IS REQUIRED BY BOTH THE STUDENT'S GUARDIAN AS WELL AS THEIR HEALTH CARE PROVIDER prior to administering any medication in school.

**CONSENT:** *I attest to the information provided. I acknowledge that it is my responsibility to inform the school of any changes to the health status of this student including health conditions, needs, medications, and/or allergies. I understand and agree that this student may receive a routine screening for vision and hearing deficiencies. I will comply with all school illness, immunization, and medication policies. I give my consent for any treatment deemed necessary in an emergency and, if necessary, the transfer of the student to a local Emergency Department. The contacts listed below have my permission to pick-up the student if I am unavailable. Furthermore, I give permission for school health staff to confidentially exchange health information - both within the school as well as with outside health care providers - for use in meeting this student's health and educational needs in school.*

| Parent/Guardian Printed Name | Parent/Guardian Signature | Date |
|---|---|---|
| | | |

| Phone Number(s) | Email |
|---|---|
| | |

| Emergency Contact 1 Name | Phone Number |
|---|---|
| | |

| Emergency Contact 2 Name | Phone Number |
|---|---|
| | |