



MINNEAPOLIS PUBLIC SCHOOLS
Health Related Services
Health Information Form
Pre K - 12

Please return this form
to the
School Health Office

Student Name: \_\_\_\_\_ Birth Date \_\_\_\_\_ Boy [ ] Girl [ ]
ID # \_\_\_\_\_ Grade/Room \_\_\_\_\_ School attended last year: \_\_\_\_\_

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 school. Health information from this form may be shared with other school staff as needed. Please complete this form and return it to school as soon as possible.

Kimberlee Reeves
Licensed School Nurse Health Services Assistant or Licensed Practical Nurse Phone C: 612-412-2133
School Pilgrim Lutheran School Year: 2013-2014

HEALTH CONCERNS

Please put a checkmark if the student has any of these health concerns:

- [ ] No Health Concerns
[ ] ADHD/ADD
[ ] Allergies (to what?)
[ ] Asthma or other breathing problems
a. Has the student ever been diagnosed by a doctor 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 problem (describe)
[ ] Bladder problems/ Bowel problems (describe)
[ ] Diabetes: [ ] Type 1 [ ] Type 2 Managed by: [ ] Diet only [ ] Oral meds [ ] Insulin injections [ ] Insulin pump
[ ] Exposure to drugs and/or alcohol before birth
[ ] Heart Problems (describe)
[ ] Is the student pregnant? Due date Does the student have children? Age of child(ren)
[ ] Seizures: Type (describe) Date of last seizure:
[ ] Social/emotional/behavioral/mental health concerns (describe)
[ ] Other health concern or significant history of problems (describe)
[ ] Activity restrictions: (describe)

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

EMERGENCIES: Does the student have a health problem that could result in an emergency? [ ] Yes [ ] No
If yes, describe:

MEDICATIONS: List ALL medications that the student takes every day or when needed. A consent is REQUIRED for ALL medication taken at school, including over the counter medications. The consent must be signed by both HEALTH CARE PROVIDER and PARENT. A new consent is needed each school year. Forms are available in the health office.
Medication Name Purpose Dose How often taken?

**Vision**

- No vision problem
- Glasses/contacts prescribed
- Wears glasses/contacts all of 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
- Frequent ear infections (more than 3 per year in past year)
- 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 does not wear
- Other (describe) \_\_\_\_\_

**Comments:** Use this space to describe problems listed.

The student attends Minneapolis Kids Program at \_\_\_\_\_ site.  Before school  After school

**HEALTH INSURANCE:**

- The student has health insurance:
  - Medical Assistance
  - Minnesota Care
  - Assured Care
  - Other (for example through work)
- The student has no health insurance

**HEALTH CARE PROVIDERS:**

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

Name of Doctor or Clinic	Location and Phone	Approximate Date of Last Exam
Primary Health Provider (regular doctor)		
Eye Specialist		
Ear Specialist		
Other Specialist (specify type):		

Hospital preference: \_\_\_\_\_

**This health information may be shared with MPS school staff as needed. If you do not want this health information shared, please contact the school nurse Kimberlee Reeves at 612-412-2133**

School Nurse Name Phone/Pager

Parent/Guardian signature: \_\_\_\_\_ Daytime phone \_\_\_\_\_

Print Parent/Guardian name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian e-mail contact: \_\_\_\_\_ (month-day-year)