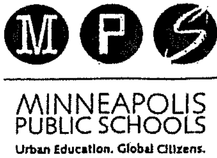

MINNEAPOLIS PUBLIC SCHOOLS
Health Related Services
Health Information Form
Pre K – 12

Please return this form to the School Health Office

Student Name: ______________________________ **Birth Date** ______________ **Boy** ☐ **Girl** ☐
First Middle Last

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.

______________________ ______________________ ______________
Licensed School Nurse Health Services Assistant or Licensed Practical Nurse Phone

School ______________________ **School Year:** ______________

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 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?

Please Turn Over and Complete Back Side ➔

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 ____________________________ at ______________

School Nurse Name Phone/Pager

Parent/Guardian signature: ______________________________ Daytime phone ______________

Print Parent/Guardian name: ______________________________ Date: ______________
(month-day-year)

Parent/Guardian e-mail contact: ______________________________