MINNEAPOLIS PUBLIC SCHOOLS
Health Related Services
Annual Health Information
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) _____

☐ Chickenpox (List month and year he/she had disease) _____

☐ Diabetes: ❒ Type 1 ❒ Type 2 Managed by: ❒ Diet only ❒ Oral meds ❒ Insulin injections ❒ Insulin pump

☐ 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: _____