Holdingford Public Schools
Health Services

Health Information Form

Student Name: _____ Date of Birth: _____

Grade / Homeroom Teacher: _____/_____

*****Please contact or meet with the school nurses if your child has health needs or concerns.*****

Health Conditions: Please indicate if your child has any of these concerns ***and explain***.

☐ **Allergies**: ☐ Bee/wasp sting Describe reaction: _____

☐ Food: _____ Describe reaction: _____

Will your child need an **EpiPen** or other allergy medicine at school? ☐ Yes ☐ No

☐ **Other allergies** (environmental/seasonal, latex, medication, etc.) **Please specify:**_____

☐ **Asthma** Known triggers: _____ ☐ Medication/inhaler (list on reverse side)

☐ **Cystic Fibrosis**

☐ **Diabetes**: ☐ Type 1 ☐ Type 2 ☐ Insulin injections ☐ Insulin pump ☐ Oral medication

☐ **Epilepsy/seizure disorder** Type: _____ Date of last seizure: _____

☐ **Ear/hearing issues**: ☐ Hearing Loss: ☐ Right ear ☐ Left ear

☐ Hearing Aids: ☐ Right ear ☐ Left ear ☐ Battery size _____

☐ Frequent ear infections ☐ Ear tubes Date placed _____

☐ **Vision issues**: ☐ Wears glasses/contacts full time ☐ Wears glasses for reading/class work only

☐ Glasses are lost/broken Date of most recent eye exam: _____

☐ **Heart condition**: _____

☐ **Kidney condition**: _____

☐ **Muscular/orthopedic concerns**: _____

☐ **Frequent stomach aches/gastrointestinal issues**: _____

☐ **Frequent headaches** ☐ Migraine headaches ☐ Medication (list on reverse side)

☐ History of head injury/concussion Date(s) _____

☐ **Neurological concerns**: ☐ Spina bifida ☐ Cerebral palsy ☐ Other: _____

☐ **ADD/ADHD** ☐ Medication (list on reverse side) ☐ Does not take medication for ADD/ADHD

☐ **Social/behavioral/communication concerns**: ☐ Autism Spectrum Disorder ☐ Other: _____

☐ **Developmental/learning concerns**: _____

☐ **Mental/emotional/psychological health concerns**: ☐ Anxiety ☐ Depression ☐ Other: _____

☐ **Surgeries** (recent or significant history): _____

☐ **Recent injury or hospitalization**: _____

☐ **Other health concerns or additional health information**: _____

*****PLEASE SEE OTHER SIDE*****

Does your child have a health condition that could result in an emergency? ☐Yes ☐No
If yes, please describe: _____

Does your child have any food sensitivities or require a special diet (medical or non-medical)? ☐Yes ☐No
If yes, please describe: _____

Activity restrictions (list activities this child must avoid): _____

Disabilities: _____

Does your child use a walker, leg braces, wheelchair, catheter, feeding tube, or other adaptive devices? ☐Yes ☐No
If yes, please list/describe: _____

Do you have any comments or other information that would help us care for your child's health needs while at school?
_____

Medications: Please list **ALL PRESCRIPTION** medications that your child takes daily or as needed. Consent forms are required yearly for any medications administered at school. Forms are available in the nurse's office or on the website.

Name of Medication	Reason / Condition	Dose	Frequency	Will this medication need to be administered at school?
				☐Yes ☐No ☐Maybe ☐Emergency Only / As Needed
				☐Yes ☐No ☐Maybe ☐Emergency Only / As Needed
				☐Yes ☐No ☐Maybe ☐Emergency Only / As Needed
				☐Yes ☐No ☐Maybe ☐Emergency Only / As Needed

If necessary, please list additional medications on a separate sheet of paper and attach to this form. Thank you.

PERMISSION TO ADMINISTER TOPICAL FIRST AID MEDICATIONS

It may be necessary for school personnel to apply topical first aid medications such as: antibiotic ointment, anti-itch cream, tooth/mouth pain relief gel, saline eye drops, etc. If you do **not** want your child to receive these medications, enter "NO" on the line following. Otherwise, it is understood that you are giving permission for school personnel to apply first aid medications. _____

SHARING HEALTH INFORMATION

This information is considered sensitive and confidential, and is viewed by the school nurses in order to update your child's health record and care plan. It will be shared only on a need-to-know basis with individuals who have regular contact with your child (teachers, bus drivers, paraprofessionals, etc.) in order to provide a safe and healthy environment for him/her. If you have questions or concerns, please contact your school nurses.

PARENT / GUARDIAN SIGNATURE: _____ DATE: _____

HOLDINGFORD PUBLIC SCHOOLS – ISD #738
P.O. Box 250, Holdingford, MN. 56340

Dr. Chris Swenson	Angela Safran	Jim Stang	Garrity Gerber
Superintendent	Secondary Principal	Elementary Principal	Business Manager
320-746-2196	320-746-4309	320-746-4461	320-746-4306

Authorization for Release of Medical Information

Last Name:	First Name:	Date of Birth:	Grade:	School:

PARENT/GUARDIAN AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. I give permission for Health Services personnel to communicate, as needed, with school staff about my child's medical condition(s).
2. I give permission for Health Services personnel to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by the medication(s).
3. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to Health Services personnel.

Parent/Guardian Signature_____ Date_____