

2011-2012
EDINA SCHOOLS Health Services
Annual Health Information – Pre K - 12

GRADE _____

Student Name: _____ Gender _____
Last Middle First
Birth Date _____ School _____ Grade _____
Street Address _____ City _____ Zip _____ Home Phone _____

Mother's Name _____ Address _____
If different from student
Home Phone _____ Work _____ Pager/Cell _____
Father's Name _____ Address _____
If different from student
Home Phone _____ Work _____ Pager/Cell _____

EMERGENCY NAMES (Persons authorized to care for student when ill and/or act in an emergency when parents cannot be reached.)
Name # 1 _____ Home Phone _____ Work/Cell Phone _____
Name # 2 _____ Home Phone _____ Work/Cell Phone _____

Dear Parent / Guardian:
Your child's health may affect his or her learning. Health information from this form assists with planning for your child's needs at school. This health information may be shared with selected school staff to provide for your child's health and safety at school. Please complete this form and return it to school as soon as possible.

PHYSICIAN _____ Phone _____
DENTIST _____ Phone _____
HOSPITAL (for emergency) _____

HEALTH CONCERNS Please check all that apply.

Identified Health Concerns

- ADHD / ADD / other learning disabilities
- Allergies (to what?) _____
- Asthma or other breathing problems
- 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) _____
- Seizures: Type (describe) _____ Date of last seizure: _____
- Social / emotional / behavioral / mental health concerns (describe) _____
- Anxiety disorder
- Depression
- Vision deficit that requires preferential seating
- Hearing deficit that requires preferential seating
- Other health concern or significant history of problems (describe) _____
- Activity restrictions: (describe) _____

Surgeries or hospitalizations in the last year. Explain _____

No Health Concerns

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

6th Graders Only

Immunizations received this past year (Date received): Td _____ MMR _____ Chickenpox (Varicella) _____
Hep. A _____ Hep. B _____ Menactra(Meningitis) _____

MEDICATIONS TAKEN EVERY DAY OR WHEN NEEDED

(This section does not serve as a medical order for medication administration.)

List **ALL** medications that your child takes.

Medication Name	Reason	Dose	How often taken?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- 1) A consent form is **REQUIRED** for all medication(s) taken at school, including non-prescription (over the counter) medications.
- 2) **The consent form must be signed by both HEALTH CARE PROVIDER and PARENT. A new consent is needed each school year.**
- 3) Forms are available in the health office and on the Edina Public Schools website www.edina.k12.mn.us/support/healthservices.

Additional information that might be helpful in understanding your student such as divorce, learning problems, etc:

In order to provide for the health and safety of your child the above information may be shared with school staff working with this student and with Emergency Response Personnel in the event that 911 is called.

Parent / Guardian signature: _____ Date _____
(month/day/year)

Print Parent / Guardian name: _____

Parent / Guardian e-mail contact: _____ Daytime phone _____

The school district intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested personal information. There will be no consequences for not providing the information. It may result in an incomplete health and safety plan for your child. The information you provide will be shared only with staff in the school district whose jobs require access to this information to ensure your child's safety and school success.
(MS Section 13.04, Subdivision2)