Harvest Preparatory
Health Related Services
Annual Health Information
K-12
2009 -2010

School ____ School Year _________________

Student Name _______________________________________ DOB _____________ Sex ____

Soc. Sec. No. ___________________ Grade/Room ______ School Last Attended ____________

Dear Parents:
Your child's health may affect his/her learning. Therefore, health information is important in planning for your child's needs at school. Health information from this form may be shared with other staff as needed. Please complete this form and return it to school as soon as possible.

_______________________ ___________________________ ____________________
Licensed School Nurse Health Services Assistant or Nurse Phone Number

<u>Health Concerns:</u> Please check if your child has any of the following:

- ○ No health concerns
- ○ ADHD/ADD
- ○ Allergies
- ○ Asthma or other breathing problems

Yes ___ No ___ a. Has your child ever been diagnosed by a doctor as having asthma?
Yes ___ No ___ b. Has your child 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 your child wheeze or cough after active playing?
d. Other breathing problems describe _________________________________

- ○ Bladder Problems/Bowel Problems Describe ___________________________________
- ○ Diabetes
- ○ Heart Problem Describe ____
  Activity Restrictions ____
- ○ Pregnant – Due Date ________ Parenting – Age of child(ren) _____________________
- ○ Seizures
- ○ Social/Emotional/Mental Health describe ______________________________________
- ○ Other Health Concerns ____

Any recent surgeries or hospitalizations? Yes _____ No ______ If yes, explain

____

<u>Emergencies:</u> Does your child have any health problems that could result in an emergency? Y or N

If yes, describe ____
____

Medication: List **ALL** medication that your child takes everyday 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 problems
____ Glasses/contacts prescribed
____ Wears glasses/contacts all the time
____ Glasses lost/broken
____ Has or had glasses but does not wear
____ Other (describe)

Hearing

____ No hearing problems
____ Frequent ear infection (more than 3 per in the past year)
____ Has ear tube(s) Date Inserted ___________
____ Hearing loss ____right ear _____ left ear
____ Hearing aid _____ right ear ____ left ear
____ Aids lost/broken
____ Has (or had aids but does not wear)
____ Other (describe)

Comments:

Health Insurance:

- ○ My child has health insurance
  Medical Assistance MN Care Assured Care Other

- ○ My child has no health insurance

HEALTH CARE PROVIDERS:

Does your child 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		

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: ______________