

Schoolcraft Learning Community

Student Health History Form 2010-11 School year



Student's Name: _____

Birthdate: _____ / _____ / _____ Date this form was completed: _____
Month Day Year First Name Initial Last Name

Name of Parent/Guardian to contact for health concerns:

_____ Daytime Phone: (____) _____

The purpose of this form is to gather information so the Schoolcraft faculty and staff can effectively shape the education experience of your child. This form will be reviewed by the school's nurse. Information will be shared on a "need to know" basis with faculty and/or staff.

About Your Child's General Physical Health

Is your child currently coping with or does your child have a history of:								
	Yes	No	Year		Yes	No	Year	
High blood pressure				Ulcer				
Heart condition				Chronic abdominal pain				
Asthma				Frequent colds				
Severe allergies				Sinus problems				
Cancer				Frequent ear infections				
Positive tuberculin test				Speech impairment				
Diabetes or hypoglycemia				Reduced hearing ability				
Skin disorder				Poor vision				
Head injury, concussion				Frequent, painful urination				
Headache, migraines				Wets or soils self				
Fainting, dizziness				Scoliosis				
Seizure disorder				Anxiety				
Bone or joint problem				Disrupted sleep patterns				

Please add comment about each item which was checked "yes" in the chart above, especially those for which your child receives regular medical supervision:

Name of your child's physician: _____ MD's Phone: () _____

When was your child last seen by this physician? _____

List operations your child had in the past two years: _____

Has your child had chicken pox? Yes No

For girls: Has your daughter started to menstruate? Yes No

If not, does she know about menstruation? Yes No

If yes, does she use medication for cramps? Yes No

Does your child have muscular and/or skeletal concerns which impact full participation? Yes No

If yes, please explain:

Does your child have asthma? Yes No

If yes, call for our Asthma Information form.

About Your Child's Allergies

Check this box if your child has no known allergies; then go to the next section No known allergies

List the medications to which your child is allergic

List the foods to which your child is allergic

Check any life threatening allergy your student has:

Insect stings (list type) _____

Food (list what food) _____

Animal (list type) _____

Medication (list name) _____

Other (list) _____

Has emergency medical treatment been needed in the past for life-threatening allergies? Yes No

If yes, when was the last emergency treatment given?

Allergies are being managed by Dr. _____ Office Phone: () _____

Will your child carry an EpiPen while at school? Yes No

With regard to life threatening allergies, check the signs that usually appear during your child's allergic response:

____ Difficult breathing

____ Rash; hives

____ Difficult swallowing

____ Nausea

____ Loss of consciousness

____ Flushed skin color

____ Swelling:

____ Unusually pale skin color

How much? _____

____ Other:

Where? _____

____ Other:

Note that Schoolcraft is a minimum of 30 minutes from Bemidji's clinic/hospital and that school personnel capable of managing an anaphylaxis emergency may not be available at all times. Please call us if you are concerned about this.

About Your Child's Medication

Complete this medication chart, listing all medications that your child routinely takes.

Name of Medication	Dose/Amount	Time Taken	Reason for Taking this Medication

Will your child need medication administered during the Schoolcraft day? Yes No

If yes, complete this information specific to the school day. *It is Schoolcraft policy that children who need medication receive that medication under staff supervision. Our students should not self-medicate unless school nurse is notified.*

Name of Medication Given at School	Dose/Amount	Time of Administration

If you bring medication to be given at school, it must be in a prescription bottle and labeled appropriately for your student. No medications will be given without a signed request from the parent/guardian and the prescribing physician. Immunization requests can be obtained from the school. **By state law, rescue inhalers for the treatment of asthma may be carried by students only after the receipt of the above information and a student demonstration of proper technique to the school nurse.**

About Your Child's Diet

Check the items which apply to your student. Note that Schoolcraft's meals feature an international menu.

- This student eats a regular, varied diet and is prepared to eat foods from other cultures.
- This student is a vegetarian of this type
 - Semi-vegetarian (no pork or beef).
 - Pesco vegetarian (no pork, beef or chicken).
 - Lacto-Ovo vegetarian (no beef, pork, chicken, fish, seafood).
 - Vegan (no beef, pork, chicken, fish, seafood, eggs or dairy).
- This student is lactose-intolerant and:
 - Uses a product like Lactaid to self-manage the intolerance.
 - Needs a lactose-free diet including no lactose in baked items.

About Your Child's Immunization History

Complete the enclosed **Pupil Immunization Record**. To comply with Minnesota statutes, this information must be completed. Note that information about exemption categories is included on the form.

About Your Child's Mental/Emotional Health

- Has your child been diagnosed with Attention Deficit Disorder (ADD) or AD/HD?◇ Yes ◇ No
- Does your child have a psychiatric diagnosis such as depression, OCD, panic/anxiety?◇ Yes ◇ No
- Does your child have an emotional health concern?◇ Yes ◇ No
- Does your child have a learning disability?◇ Yes ◇ No
- Is your child currently seeing a professional to address mental/emotional health concerns?◇ Yes ◇ No

If "yes" to any question above, attach a statement which describes the concern and the management plan, specifically your child's behavior plan, access to professional therapy, and medication history.

Working Together for Your Child's Health

It is Schoolcraft policy to call parents/guardians when your child is unable to continue the day because of injury or illness. In this situation, we expect that you will come to get your student within a reasonable time frame. Please provide at least two names and phone numbers for this purpose.

Name _____ Daytime Phone (____) _____

Name _____ Daytime Phone (____) _____

We would like to partner with you in developing a healthy child. If we have concerns to discuss, who should we contact? Name _____ Daytime Phone (____) _____

Because children grow, changes to this health form may be needed during the school year. Please provide that information in writing. Who has permission to adapt and/or add information on this health form?

Name _____

What Have We Forgotten?

Provide additional information about your child's health which may have been neglected on this form. We are particularly interested in information which has impact upon your child's educational experience.

Parent/Guardian Authorization about Health Care

This health information is current and truthful based on my knowledge of the student it describes. The student has my permission to participate in all school activities except as noted on this form. If I cannot be reached in an emergency, I give my permission for the School to seek medical assistance and for that physician to provide care for my child.

Parent/Guardian Signature: _____ Date: _____