

ZUMBROTA-MAZEPPA SCHOOL HEALTH INFORMATION FORM

PART 1 Parent or guardian to complete. Parent or guardian is encouraged to participate in the development of an Individual Health Care Plan, if needed.				
Student Name	Last	First	Middle	Sex <input type="radio"/> M <input type="radio"/> F
Date of Birth				
School	Grade	Parent/Guardian Name		
Home Phone	Mother Cell	Father Cell		
My child has a medical condition that may affect his or her school day <input type="radio"/> No <input type="radio"/> Yes (please complete Part 2)				
Parent or Guardian Name (Print or Type)			Email Address	
Parent or Guardian Signature			Date	
PART 2 Complete ALL boxes that apply to your child. Parent/guardian is responsible for providing the school with any medication, special food, or equipment that the student will require during the school day. Check with the school office to obtain correct medication forms. If an individual school health care plan is indicated, parent/guardian is responsible for providing the school nurse with necessary medical information and forms. Please see link to locate your building's school nurse and forms: http://www.zmschools.us/departments/welcome-health-services				
<input type="checkbox"/>	ALLERGIES			
Allergy Type				
<input type="checkbox"/> Food List food(s) _____				
<input type="checkbox"/> Bee/Insect Sting				
<input type="checkbox"/> Other (List) _____				
Reactions <input type="checkbox"/> Type <input type="checkbox"/> Mild <input type="checkbox"/> Severe Date of last severe reaction: _____				
Describe your child's allergic reaction symptoms: _____				
<ul style="list-style-type: none"> ▪ Does your child require classroom designation (i.e. peanut, nut, dairy, or seafood "free" etc.)? <input type="radio"/> No <input type="radio"/> Yes ▪ Does your child need to sit at a specified allergy free area in the cafeteria? <input type="radio"/> No <input type="radio"/> Yes ▪ Will your child be riding the bus to school? <input type="radio"/> No <input type="radio"/> Yes 				
Currently prescribed medications and treatment:				
<input type="checkbox"/> Oral antihistamine (Benadryl, etc.) <input type="checkbox"/> Epinephrine <input type="checkbox"/> Other _____				
(A Medication Authorization Form is required for all medications at school. See next page)				
<input type="checkbox"/>	FOOD INTOLERANCE			
<input type="checkbox"/> Due to gastrointestinal (digestive) distress		List foods: _____		
<input type="checkbox"/> Due to religious preferences		List foods: _____		
<input type="checkbox"/>	ASTHMA			
Triggers <input type="checkbox"/> Exercise <input type="checkbox"/> Environmental <input type="checkbox"/> Other (list) _____				
Symptoms				
<input type="checkbox"/> Chest tightness, discomfort, or pain <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Throat itch, tightness, or soreness				
<input type="checkbox"/> Coughing <input type="checkbox"/> Hoarseness <input type="checkbox"/> Wheezing				
<input type="checkbox"/> Other _____ Date of last hospitalization for asthma _____				
Currently prescribed medications and treatment				
<input type="checkbox"/> Inhalers <input type="checkbox"/> Oral antihistamines <input type="checkbox"/> Oral steroids Nebulizer <input type="checkbox"/> Oral Bronchodilator <input type="checkbox"/> Peak flow monitoring				
Will your child require medication at school? <input type="radio"/> No <input type="radio"/> Yes				

(A Medication Authorization Form is required for all medications at school. See next page)	
<input type="checkbox"/> DIABETES (Contact school nurse to discuss Individualized Health Plan)	
Currently prescribed medications and treatments	
<input type="checkbox"/> Insulin <input type="checkbox"/> Syringe <input type="checkbox"/> Pen <input type="checkbox"/> Pump <input type="checkbox"/> Blood sugar testing <input type="checkbox"/> Carbohydrate counting <input type="checkbox"/> Glucagon <input type="checkbox"/> Oral medication(s) List medication(s) _____ Date of last hospitalization related to Diabetes _____	
<input type="checkbox"/> SEIZURE DISORDER	
Type of seizure	
<input type="checkbox"/> Absence (staring, unresponsive) <input type="checkbox"/> Complex partial <input type="checkbox"/> Generalized tonic-clonic (grand mal, convulsive) Other (explain) _____ Date of last seizure _____ Length of seizure _____ Physical education restrictions <input type="radio"/> No <input type="radio"/> Yes Currently prescribed medications _____ Medications needed <u>IN SCHOOL</u> <input type="radio"/> No <input type="radio"/> Yes List medication(s) _____	
(A Medication Authorization Form is required for all meds at school. See below)	
<input type="checkbox"/> OTHER HEALTH CONDITIONS	
<input type="checkbox"/> ADHD/ADD <input type="checkbox"/> Arthritis <input type="checkbox"/> Bathroom issues <input type="checkbox"/> Bleeding disorder (be specific) _____ <input type="checkbox"/> Emotional concerns <input type="checkbox"/> Heart condition (be specific) _____ <input type="checkbox"/> Kidney disease <input type="checkbox"/> Physical disability (be specific) _____ Other (explain) _____ Special procedures (e.g. catheterization, cardiac monitor, etc.) required <u>IN SCHOOL</u> <input type="radio"/> No <input type="radio"/> Yes (explain) _____	
MEDICATION NEEDED <u>IN SCHOOL</u> <input type="radio"/> No <input type="radio"/> Yes	
List medication(s) _____	
A Medication Authorization form must be completed by your child's physician for all medication (prescription and over-the-counter) indicated the medication, dosage, and time the medicine is to be given. See "Health Services" link on the district website for policy and forms. http://www.zmschools.us/departments/welcome-health-services	
<input type="checkbox"/> VISION CONDITIONS	<input type="checkbox"/> HEARING CONDITIONS
<input type="checkbox"/> Contacts <input type="checkbox"/> Glasses <input type="checkbox"/> Non-correctable <input type="checkbox"/> Other _____	<input type="checkbox"/> Hearing aid(s) <input type="checkbox"/> Non-correctable <input type="checkbox"/> Other _____
<input type="checkbox"/> PHYSICAL RESTRICTIONS	
Does your child's health condition restrict participation in physical education? <input type="radio"/> No <input type="radio"/> Yes If yes, please explain restrictions _____ Will your child be riding the bus to school? <input type="radio"/> No <input type="radio"/> Yes Do you wish to have a conference with the school nurse? <input type="radio"/> No <input type="radio"/> Yes Do you wish to have a conference with the school counselor? <input type="radio"/> No <input type="radio"/> Yes	
PART 3 School nurse to complete if parent or guardian indicates medical condition(s).	
Health condition noted	Individual health care plan or procedure needed
_____	_____
ZM School Nurse	Date
Notes _____	

RETURN COMPLETED FORM TO SCHOOL OFFICE