KENYON-WANAMINGO 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

_____

Date of Birth Sex (M/F) Grade Parent/Guardian Name

_____

Home Phone Mother Cell Father Cell

My child has a medical condition that may affect his or her school day: Y or N **(if yes, 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 nurse 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 our school nurse and forms: https://www.kw.k12.mn.us/cms/One.aspx?portalId=26923240&pageId=27161590

ALLERGIES

☐ Food List food(s)_____

☐ Bee/Insect Sting

☐ Other (List) _____

Reactions ○ Mild ○ Severe Date of last severe reaction: _____

Describe your child's allergic reaction symptoms: _____

_____

- ❏ Does your child need to sit at a specified allergy free area in the cafeteria? ⚬ No ⚬ Yes
- ❏ Will your child be riding the bus to school? ⚬ No ⚬ Yes

Currently prescribed medications and treatment:

☐ Oral antihistamine (Benadryl, etc.) ☐ Epinephrine ☐ Other _____

(A Medication Authorization Form is required for all medications at school. See next page.)

FOOD INTOLERANCE

☐ Due to gastrointestinal (digestive) distress List foods: _____

☐ Due to religious preferences List foods: _____

ASTHMA

Triggers ☐ Exercise ☐ Environmental ☐ Other (list) _____

Symptoms

⚬ Chest tightness, discomfort, or pain ⚬ Difficulty breathing ⚬ Throat itch, tightness, or soreness ⚬ Coughing

⚬ Hoarseness ⚬ Wheezing ⚬ Other _____ Date of last hospitalization for asthma_____

Currently prescribed medications and treatment

☐ Inhalers ☐ Oral antihistamines ☐ Oral steroids Nebulizer ☐ Oral Bronchodilator ☐ Peak flow monitoring

Will your child require medication at school? ⚬ No ⚬ Yes

(A Medication Authorization Form is required for all medications at school.)

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DIABETES ❒ Type I ❒ Type II

Currently prescribed medications and treatments

□ Insulin ○ Syringe ○ Pen ○ Pump □ Blood sugar testing □ Carbohydrate counting □ Glucagon

□ Oral medication(s) List medication(s) _____

Date of last hospitalization related to Diabetes: _____

SEIZURE DISORDER

Type of seizure

□ Absence (staring, unresponsive) □ Complex partial □ Generalized tonic-clonic (grand mal, convulsive)

Other (explain) _____

Date of last seizure _____ Length of seizure _____

Physical education restrictions ○ No ○ Yes

Currently prescribed medications _____

Medications needed ***IN SCHOOL*** ○ No ○ Yes List medication(s) _____

(A Medication Authorization Form is required for all medications at school.)

OTHER HEALTH CONDITIONS

□ ADHD/ADD □ Arthritis □ Bathroom issues □ Bleeding disorder (be specific) _____ □ Emotional concerns

□ Heart condition (be specific) _____ □ Physical disability (be specific) _____

□ Kidney disease □ Other (explain) _____

Special procedures (e.g. catheterization, cardiac monitor, etc.) required ***IN SCHOOL*** ○ No ○ Yes

(Explain) _____

MEDICATION NEEDED *IN SCHOOL* ○ No ○ 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 Office" link on the district website for policy and forms.

VISION CONDITIONS

□ Contacts □ Glasses □ Non-correctable

□ Other _____

HEARING CONDITIONS

□ Hearing aid(s) □ Non-correctable

□ Other _____

PHYSICAL RESTRICTIONS

Does your child's health condition restrict participation in physical education? ○ No ○ Yes

If yes, please explain restrictions _____

Will your child be riding the bus to and/or from school? ○ No ○ Yes

Do you wish to have a conference with the school nurse? ○ No ○ Yes

Do you wish to have a conference with the school counselor ○ No ○ 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

_____

Kenyon-Wanamingo School Nurse _____ Date _____

Notes

_____

_____

RETURN COMPLETED FORM TO SCHOOL OFFICE