**This form REQUIRED yearly for the health office.*
*Immunization record: **ONLY** for **K & before** starting **7th** grade*

OLG† Annual Health Information Form 2017/18 Grade _____

Student Name:_____**Gender/ DOB** _____
Last First Middle

Address _____**City**_____ **Zip**_____ **Home Phone**_____

Parent Name _____ **Address** _____
(If different from student)
Cell # _____ **Work #** _____

Parent Name_____ **Address** _____
(If different from student)
Cell # _____ **Work #** _____

Parent / Guardian email contacts: _____ _____

EMERGENCY NAMES (*Persons authorized to care for student when ill and/or act in an emergency when parents cannot be reached.*

Name _____**Relation**_____**Phone**_____ **Cell #**_____

Name _____**Relation**_____**Phone** _____**Cell #** _____

PHYSICIAN_____Phone_____

DENTIST _____Phone_____

HOSPITAL (*for emergency*) _____

HEALTH CONCERNS **Please check all that apply.**

- ❑ ADHD / ADD / Other learning disabilities _____
- ❑ Allergies (list) _____
- ❑ Asthma or other breathing problems
- ❑ Chickenpox (List month and year he / she had disease) _____
- ❑ Food intolerance (describe)_____
- ❑ 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 (describe) _____
- ❑ Activity restrictions: (describe) _____
- ❑ **Surgeries or hospitalizations in the last year. Explain.**_____

❑ **No Health Concerns**

Please Turn Over and Complete the back

EMERGENCIES: Does your child have a health problem that could result in an emergency? ☐ Yes ☐ No

If yes, describe: _____

_____

_____

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?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If your child needs to take medication at school, please consider the following:

1. The **Authorization for Administration of Medication form** is **REQUIRED** for all medication(s) taken at school, including non-prescription (over the counter) medications. Students must take all medications at school through the health office unless otherwise arranged individually with the licensed school nurse.

2. **The Authorization for Administration of Medication form must be signed by both the HEALTH CARE PROVIDER and PARENT. A new consent is needed each school year.**

3. Forms are available on the website under services/ health services.

Is there any other information that might be helpful for us to know about your child or circumstances at home that could affect him/her at school?

_____

_____

_____

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 name: (Print Name)_____

Parent / Guardian Signature: _____Date _____

(month/day/year)

The school 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)