Child's Name:_____
(Last) (First) (Middle)
Date of Birth:_____ School:_____ Grade/Program:_____

Please indicate if your child has any of these concerns and explain:

☐ **No Health Concerns**

☐ Allergic Reactions to be aware of at school (to what?)

_____

(Describe reaction) _____☐ Medication (see below)

If your child will require an epi-pen, you will need to complete a consent form, signed by your pediatrician.

☐ Attention Disorder: ☐ ADD ☐ ADHD ☐ Medication (see below) ☐ Does not take medication for ADD / ADHD

☐ Asthma Known Triggers:_____ ☐Medication (see below)

☐ Autism Spectrum Disorder , age of diagnosis _____

☐ Diabetes: ☐ Type 1 ☐ Type 2 ☐Insulin Injections ☐Insulin Pump ☐Oral medication

☐ Heart Problem (describe)

_____

☐ Hearing Loss: ☐ right ear ☐ left ear ☐ Hearing Aids: ☐ right ear ☐left ear

☐ Vision: ☐ Wears glasses /contacts ☐ wears in classroom only ☐ lost / broken

☐ Neurological_____

☐ Seizures: Type: _____ Date of last seizure: _____

☐ Recent surgery or hospitalization:

Explain_____

☐ Mental Health concerns _____

☐ Other health concerns or additional health information:

_____

_____

Emergencies: Does your child have a health concern that could result in an emergency? ☐YES ☐NO

If yes, please describe:_____

Medications: List All medications that your child takes every day or when needed. *Consent forms are required yearly for medications administered at school (doctor order is also needed for prescription medications). Forms are available on theHopkins Website or from your building health office.

Name of Medication	Purpose	Dose	How Often Taken

Does your child need a special diet*? ☐YES ☐ NO If yes, please describe:

_____

*If dietary restrictions are medically necessary, a Special Diet Statement must be completed by your child's doctor before school can provide food substitutions. Forms are on the Hopkins website or in the health office. Caregivers may request lactose free milk without a doctor signature.

Does your child have/receive any of the following (through school or outside of school): ☐ IEP ☐ 504 ☐Speech ☐Occupational Therapy ☐Physical Therapy ☐Counseling/Therapy ☐ Other (indicate):

_____

_____

The above information is helpful in establishing a comprehensive picture of your child's health and safety needs while at school. The information on this form will be entered into the district's secure electronic data system and considered confidential. There will be no consequences for not providing the information. However, 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, Subdivision 2)

PARENT/GUARDIAN/CAREGIVER SIGNATURE: _____DATE:_____

Primary Phone: _____

Emergency Contact/Authorized to Pick Up Student and Phone Number: _____