CLOQUET PUBLIC SCHOOLS

GRADE _____

CLOQUET PUBLIC SCHOOLS • Annual Health Information

STUDENT NAME _____
(Please print) *Last Name* *First Name* *Middle Initial*

Health information from this form assists with planning for your child's needs at school.

PHYSICIAN _____ **Phone** _____

DENTIST _____ **Phone** _____

HOSPITAL *(for emergency)* _____

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

- ☐ **Identified Health Concerns**
  - ☐ ADHD/ ADD / Other learning disabilities
  - ☐ Allergies *(list)* _____
  - ☐ Anxiety disorder
  - ☐ Asthma or other breathing problems
  - ☐ Bladder problems / Bowel problems *(describe)* _____
  - ☐ Depression
  - ☐ Diabetes: Type 1 __ Type 2__ Managed by: *(please circle)* Diet only Oral meds Insulin injections Insulin pump
  - ☐ Food intolerance *(describe)* _____
  - ☐ Hearing *(explain)* _____
  - ☐ Heart problems *(describe)* _____
  - ☐ Seizures: Type *(describe)* _____ *Date of last seizure:* _____
  - ☐ Social/ Emotional / Behavioral / Mental health concerns *(describe)*
  - ☐ Vision *(explain)* _____
  - ☐ Other health concerns or significant history of problems *(describe)* _____
  - ☐ Activity restrictions*(describe)* _____
- ☐ **Surgeries or hospitalizations in the last year. Explain.** _____
- ☐ **No Health Concerns**

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 at home and at school.

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 required each school year.**
3. Forms are available in the health office and the Cloquet Public Schools website http://www.isd94.org > Programs > Health and Nursing 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 *9-1-1* is called.

Parent / Guardian Name *(please print)* _____

Parent / Guardian Signature: _____ **Date:** _____

The school district 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.