

ANNUAL HEALTH INFORMATION
2018-2019 School Year

LUVERNE PUBLIC SCHOOLS
RETURN TO SCHOOL
HEALTH OFFICE

NAME: _____

SEX: Male Female

BIRTH DATE: _____

GRADE ENTERING THIS YEAR: _____

HEALTH CONCERNS: Please check if your student is subject to the following conditions:

___ VISION PROBLEMS: ___ Glasses Prescribed ___ Wears Glasses/Contacts Full Time ___ Classroom Only

___ EAR/HEARING PROBLEMS (check all that apply) ___ Frequent ear infections ___ Hearing loss ___ Has ear tubes ___ Wears hearing aid

Check which ear(s) affected
Right Left
___ ___
___ ___
___ ___

Date tubes inserted: _____

___ ALLERGIES:(To what?) _____ ___ ASTHMA ___ DIABETES

___ HEART DISEASE ___ SEIZURES ___ BLADDER /BOWEL PROBLEMS ___ MENTAL HEALTH ISSUES

COMMENTS: Explain items checked above and how school staff should handle any problems.

MEDICATIONS: Please list the medications your student takes either daily or occasionally.

Medication Name	Purpose	Dosage	How often taken?
-----------------	---------	--------	------------------

*School District Policy states that any student taking prescription medication during the school day must have a written consent form signed by the parent/guardian and physician/licensed prescriber. The medication must be in the original pharmacy container. The consent forms may be obtained from the Health Office or www.isd2184.net.

EMERGENCIES: Does your student have a health problem, which could result in an emergency? ___ Yes ___ No

If yes, describe: _____

In case of emergency, if you cannot be reached, who shall be called?

Name: _____ Phone: _____

MEDICATION CONSENT:

The Luverne Schools has acetaminophen (generic Tylenol) and ibuprofen (generic Advil) available for students with complaints of headache and/or muscle aches. Written parent/guardian permission must be on file for students to receive acetaminophen or ibuprofen at school, by signing this form the parent/guardian gives consent for acetaminophen or ibuprofen to be given by the school nurse or her designee.

Signature of parent/guardian

Daytime Phone #

Date

Home Phone #

Cell Phone #

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. If this form is not completed 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. School Nurse - Phillip Paquette, RN