ZUMBROTA-MAZEPPA 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	Sex ○ M ○ F	Date of Birth

School	Grade	Parent/Guardian Name

Home Phone	Mother Cell	Father Cell

My child has a medical condition that may affect his or her school day ○ No ○ Yes (please 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 office 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 your building's school nurse and forms: http://www.zmschools.us/departments/welcome-health-services

☐ **ALLERGIES**

Allergy Type

☐ Food List food(s) ________________________________

☐ Bee/Insect Sting

☐ Other (List) ________________________________

Reactions ☐ Type ☐ Mild ☐ Severe Date of last severe reaction: ________________

Describe your child's allergic reaction symptoms: ________________________________

____

- Does your child require classroom designation (i.e. peanut, nut, dairy, or seafood "free" etc.)? ○ No ○ Yes
- 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. See next page**)

☐ **DIABETES (**Contact school nurse to discuss Individualized Health Plan**)**

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 meds at school. See below**)

☐ **OTHER HEALTH CONDITIONS**

☐ ADHD/ADD ☐ Arthritis ☐ Bathroom issues ☐ Bleeding disorder (be specific) ____________________
☐ Emotional concerns ☐ Heart condition (be specific) ____
☐ Kidney disease ☐ Physical disability (be specific) _______________________________________

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 Services" link on the district website for policy and forms. http://www.zmschools.us/departments/welcome-health-services

☐ **VISION CONDITIONS**	☐ **HEARING CONDITIONS**
☐ Contacts ☐ Glasses ☐ Non-correctable ☐ Other _________________________________	☐ 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 school? ○ 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

____ ____

ZM School Nurse | Date

Notes____

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RETURN COMPLETED FORM TO SCHOOL OFFICE