Buffalo Hanover Montrose
BHM SCHOOLS

HEALTH AND EMERGENCY FORM

Office Only:
School Year in effect:
20 22 /20 23

Student Name

Student Information

Grade____ Gender ____ Birthdate _____ Teacher _____

Parent/Guardian

(Primary residence/custodial parent) ☐ ☐ Check for unlisted phone number

Name		Relationship	
Address		City/State/Zip	
Home Phone		Work Phone	
Cell Phone		Other Phone	
E-Mail #1		E-Mail #2	

Parent/Guardian

☐ ☐ Check for unlisted phone number

Name		Relationship	
Address		City/State/Zip	
Home Phone		Work Phone	
Cell Phone		Other Phone	
E-Mail #1		E-Mail #2	

Emergency Contact (other than parent/guardian - parents will be notified first for illness/emergency)

First Contact		Second Contact	
Relationship		Relationship	
City		City	
Phone		Phone	

PLEASE NOTIFY THE SCHOOL IF ANY OF THE ABOVE INFORMATION CHANGES DURING THE SCHOOL YEAR

The following is a one time permission that will follow your child while enrolled in Buffalo-Hanover-Montrose Schools.
Should you change your mind, please notify your child's school in writing.

I have received "Minnesota Department of Health Potassium Iodide (KI): What it is and what it does".

My Child MAY ☐ MAY NOT ☐

receive potassium iodide at the recommended dose as directed by the Minnesota Department of Health in the event of a Nuclear Incident at the Monticello Nuclear Power Plant.

My child has a known iodine allergy Yes ☐ No ☐

**Please note, students without completed permission forms WILL NOT be offered KI in the event of a nuclear incident.

Signature _____ Date _____
Parent/Guardian

PLEASE COMPLETE BOTH SIDES

HEALTH INFORMATION

Student Name

****Please note: It is the parent's responsibility to alert the bus company of any health concerns the student may have.****

Privacy statement: In accordance with the Minnesota Government Data Privacy Act, the information you provide *may* be shared with district staff involved with your child based on an educational need. Any information shared with others cannot be done so without your permission. School personnel are mandated reporters for suspected child abuse/neglect as well as suspected excessive/habitual use of illegal drugs by a parent or guardian. You have the right to withhold health information however, in doing so the school may not be able to provide the safest environment for your child.

Does Your Child Have: Please check ALL that apply

☐ **Asthma** ☐ I have completed an asthma action plan for this school year.
☐ I need an asthma action plan for my student for this school year.
Inhalers ☐ Kept in health office.
☐ Kept with student.
An Action Plan must be completed annually.

☐ **Allergies**
List _____
Treatment _____
Emergency Medications? Y ☐ N ☐
☐ Antihistamine (e.g. Benadryl, Zyrtec) ☐ Epinephrine Auto Injector (e.g. Epi Pen, AuviQ)
If a student uses emergency medications, an Allergy Action Plan must be completed annually.
*****If accommodations are needed for school meals (e.g. allergy to certain foods, lactose intolerant, gluten sensitivity), parent MUST contact nutrition services at 763-682-8477 or email khinrich@bhmschools.org*****

☐ **ADD/ADHD**
Medications _____
Given: ☐ At Home ☐ At School

☐ **Bleeding Disorders (ie: ITP, hemophilia)**
Describe _____

☐ **Cancer** Type _____

☐ **Diabetes**
☐ Type I Treatment _____
☐ Type II Treatment _____
Please complete a Diabetes School Management and Emergency Plan annually.

☐ **Headaches** ☐ **Migraine** ☐ **Non Migraine (greater than 4 a month)**
☐ Medications as needed _____
_____
Family must supply student's medications

☐ **Heart Condition**
☐ Murmur with no limitations
☐ Other
Describe _____
Medications _____

☐ **Mental Health**
Describe _____
Medications _____

☐ **Orthopedic Concerns**
Type _____
☐ Limitations
Describe _____
☐ No Limitations

☐ **Seizure**
☐ Febrile only (suggest Tylenol/Ibuprofen in health office)- (no health plan necessary)
☐ Other Describe _____
Medications _____
Please complete a Seizure Health and Emergency Plan annually.

☐ **Other** (ie: activity restrictions, neurological, mobility, hearing, vision problems/Color Vision Deficiency, special dietary needs) Describe concern:
_____
_____
_____

Doctor _____ **Clinic** _____

Signature _____
Parent/Guardian

To consult with the school nurse please contact Heidi Gallart, RN at 763-682-8514 or at hgallart@bhmschools.org for elementary schools or Karen Schultz, RN at 763-682-8120 or at kschultz@bhmschools.org for secondary schools