



HEALTH AND EMERGENCY FORM

Office Only:
School Year in effect:
20__ / 20__

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
Parent/Guardian

Date

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.

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

Allergies

List _____

Treatment _____

Emergency Medications? Y N

Antihistamine Epinephrine Auto Injector
 (e.g. Benadryl, Zyrtec) (e.g. Epi Pen, AuviQ)

If a student uses emergency medications, an Allergy Action Plan must be completed annually.

Heart Condition

Murmur with no limitations

Other _____

Describe _____

Medications _____

Mental Health

Describe _____

Medications _____

ADD/ADHD

Medications _____

Given: At Home At School

Orthopedic Concerns

Type _____

Limitations _____

Describe _____

No Limitations _____

Bleeding Disorders (ie: ITP, hemophilia)

Describe _____

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.

Cancer Type _____

Diabetes

Type I Treatment _____

Type II Treatment _____

Please complete a Diabetes School Management and Emergency Plan annually.

Other (ie: activity restrictions, neurological, mobility, hearing, vision problems, special dietary needs)
 Describe concern: _____

<p>Doctor _____</p> <p>Signature _____</p> <p style="text-align: center;">Parent/Guardian</p>	<p>Clinic _____</p>
--	----------------------------