Buffalo Hanover Montrose
BHM SCHOOLS

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 _____ 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 763-682-8818 or at hgallart@bhmschools.org for elementary schools
Erica Kindt, RN at 763-682-8211 or at ekindt@bhmschools.org for middle school
Karen Schultz, RN at 763-682-8120 or at kschultz@bhmschools.org for high school/PRIDE