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.

Allergies

List

Treatment

Emergency Medications? Y N

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

If a student uses <u>emergency</u> 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

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