

## HEALTH AND EMERGENCY FORM

Office Only: School Year in effect: 20\_\_\_/20\_\_\_

Student Name

Student Information	on Grade	Gender	Birthdate	Teacher
Parent/Guardian Name	(Frimary residence)	custodiai parent)		Check for unlisted phone number
			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 Co	ontact (other than	parent/guardian -	parents will be noti	fied first for illness/emergency)
First Contact			Second Contact	
Relationship			Relationship	
City			City	
Phone			Phone	
PLEASE NOTIFY THE	E SCHOOL IF ANY	OF THE ABOVE IN	FORMATION CHANG	GES DURING THE SCHOOL YEAR
I have received " receive potassium ioo Nuclear Incident at t	Should you Minnesota Depart My dide at the recomm he Monticello Nuc My child has	a change your mind, pleas ment of Health Pota y Child MAY ended dose as direct lear Power Plant. a known iodine aller	e notify your child's school is ssium Iodide (KI): W MAY NOT eed by the Minnesota I rgy Yes I	uffalo-Hanover-Montrose Schools. in writing. hat it is and what it does". Department of Health in the event of a No ed KI in the event of a nuclear incident.
				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.	Headaches Migraine Non Migraine (greater than 4 a month)				
	I need an asthma action plan for my student for this school year.	Medications as needed				
Inhalers	Kept in health office.					
	Kept with student.	Transite annual annuals at densite an directions				
An Act	tion Plan must be completed annually.	Family must supply student's medications				
Allergies		Heart Condition				
List		Murmur with no limitations				
		Other				
Treat	iment	Describe				
		Medications				
Eme	rgency Medications? Y N					
	Antihistamine Epinephrine Auto Injector	Mental Health				
	(e.g. Benadryl, Zyrtec) (e.g. Epi Pen, AuviQ)	Describe				
	nt uses <u>emergency</u> medications, an ction Plan must be completed annually.	Medications				
ADD/AI	OHD	Orthopedic Concerns				
		Туре				
Medic	ations	Limitations Describe				
Giver	h: At Home At School	No Limitations				
Bleeding	Disorders (ie: ITP, hemophilia)	Seizure				
_		Febrile only (suggest Tylenol/Ibuprofen in health office)-(no health plan necessary)				
Des	scribe	Other Describe				
		Medications				
Cancer	Туре	Please complete a Seizure Health and Emergency Plan annually.				
Diabetes		Other (ie: activity restrictions, neurological, mobility,				
Туре	I Treatment	hearing, vision problems, special dietary needs)				
Туре	II Treatment	Describe concern:				
	mplete a Diabetes School Management					
and Eme	rgency Plan annually.					
Doctor		Clinic				
Signature	Signature Parent/Guardian					

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