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

School Health Services Notification

Parent/Guardians: The following is a one time notification that will follow your student while enrolled in BHM Schools.
Please sign your acknowledgement below.

The BHM School District Medication Policy requires a licensed prescriber signature for all prescription medication and a parent/guardian signature on all medications given during school hours. All medication permission forms, Allergy Action Plans, Asthma Action Plans, Diabetes Orders, Seizure Action plans and Treatment Plans (Enteral feeding orders, Catheterization orders, Ostomy care orders etc) MUST be provided by the student's parent/guardian to the health office annually and are only active until 1 year after the date it was originally signed (unless otherwise indicated by provider).

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