School District 622
ST PAUL | MAPLEWOOD | OAKDALE
Ready for tomorrow

ISD 622 Health Services
Health & Emergency Information

Please return this form to the Health Office

Student: _____ Grade: ____ Gender: _____ Birthdate: ___/___/___
Last First MI

Primary Address: _____ Phone: _____
Street City State Zip

Dear Parent/Guardian:

A student's health may affect his or her learning. Therefore, updated health information is important. The following information will be held in confidence and disclosed to school personnel to the extent necessary to protect the health and safety of the student. This form should be completed each school year. Please complete this form and return it to the school Health Office as soon as possible.

Thank you
ISD 622 Health Services

HEALTH INFORMATION

Health Concerns
Please put a ✔ if the student CURRENTLY HAS or HAS HAD IN THE PAST any of these health concerns:

- ☐ **No Health Concerns**
- ☐ Allergies (if yes, to what): _____
  - Anaphylactic/Life threatening? ☐ **Yes** *Needs care plan ☐ **No**
- ☐ Asthma or breathing problems (if yes, see below):
  - Has the student had episode(s) of wheezing in the last 12 months? ☐ **Yes** *Needs care plan ☐ **No**
  - Has the student had to take medication to resolve breathing problems in the last 12 months? ☐ **Yes** *Needs care plan ☐ **No**
- ☐ Bladder/Bowel problems (if yes, describe): _____
- ☐ Diabetes (if yes, see below): *Needs care plan
  - Type (I or II): _____
  - Managed by: ☐ Diet only ☐ Oral medication ☐ Insulin injections ☐ Insulin pump
- ☐ Diagnosed diet restrictions/needs (if yes, describe): _____
- ☐ Heart problems (if yes, describe): _____
- ☐ Seizures (if yes, see below): *Needs care plan
  - Type (describe) _____ Date of last seizure: _____
- ☐ Social/Emotional/Mental Health concerns (if yes, describe): _____
- ☐ Recent surgeries or hospitalizations (if yes, describe): _____
- ☐ Activity restrictions (if yes, describe): _____
  ***Note**: If yes, a current written note from your provider stating the restrictions and length of restrictions is needed in the health office

- ☐ Autism
- ☐ Blood disease
- ☐ Cancer
- ☐ Genetic/Congenital disorder
- ☐ Vision impaired
- ☐ Head injury/Concussion
- ☐ Hearing impaired
- ☐ Migraines
- ☐ Other: _____

Health Insurance

☐ The student HAS health insurance

☐ The student DOES NOT HAVE health insurance. Would you like assistance with applying? ☐ **Yes** ☐ **No**

Health Care Providers

Primary Care Provider	Clinic/Location	Phone Number

Hospital Preference	Address	Phone Number

***Note**: In case of an emergency, our procedure will be to attempt to contact the parent/guardian. Paramedics or local police may be called for assistance. Your student will be taken to the most appropriate hospital for emergency care if no other arrangements have been made.

Emergency Contacts

Parent/Guardian 1: _____
Print Name Primary Phone Number Work Phone Number

_____
Email Address

Parent/Guardian 2: _____
Print Name Primary Phone Number Work Phone Number

_____
Email Address

Emergency Contact: _____
Print Name Relationship Phone Number

Emergency Contact: _____
Print Name Relationship Phone Number

Custody Issue ☐ Yes ☐ No

***Note**: If custodial issues are involved, a copy of decree must be on file at school.

This information is current and correct. I understand that it is my responsibility as the parent/guardian to notify the school of new or existing health concerns or any changes to contact information. I understand that this health history form must be updated every school year.

_____ _____ _____
Parent/Guardian Signature Printed Name Date