



320-453-2900 www.evww.k12.mn.us

STUDENT HEALTH INFORMATION FORM

Student First Name:		Last Name:		Date of Birth:	GR:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian #1 Name:		Relationship to Student:		Phone Number:		
Parent/Guardian #2 Name:		Relationship to Student:		Phone Number:		
IMMUNIZATIONS REQUIRED (Updated immunizations need to be provided to the School Nurse prior to starting Kindergarten, 7th and 12th grade.)						
Entering Kindergarten: Students are required to have: (4) DtaP, (4) Polio, (3) Hep B, (2) MMR, (2) Varicella. Entering 7th Grade: Students are required to have: 1st dose of Meningococcal ACWY (MCV4) and Tdap booster after age 11; along with all previously required immunizations. Entering 12th Grade: Students are required to have: 2nd dose of Meningococcal ACWY (MCV4) after age 16; along with all previously required immunizations.						
<input type="checkbox"/>	My child has COMPLETED the required immunizations for their grade level AND documentation of this has been given to the school nurse. (Please provide if not yet done so.)					
<input type="checkbox"/>	My child is EXEMPT for some or all immunizations either by conscientious objection or medical reasons. Signed and notarized documentation has been given to the school nurse.					
HEALTH HISTORY (New Students, check all conditions your child currently has or was treated for in the past.) (Returning Students, check conditions that need to be updated.)						
	Condition	Details				
<input type="checkbox"/>	Returning Students Only: Nothing has changed since the previous school year.					
<input type="checkbox"/>	Diabetes					
<input type="checkbox"/>	Seizures					
<input type="checkbox"/>	Allergies (please list them)	Is an EpiPen or Benadryl needed at school?: <input type="checkbox"/> No <input type="checkbox"/> Yes Allergic to:				
<input type="checkbox"/>	Special Diet OR Food Restrictions					
<input type="checkbox"/>	Asthma	History of: <input type="checkbox"/> OR Current: <input type="checkbox"/> Will an inhaler be needed at school?: <input type="checkbox"/> No <input type="checkbox"/> Yes				
<input type="checkbox"/>	Lung/Respiratory Disease					
<input type="checkbox"/>	Heart/Cardiovascular Disease					
<input type="checkbox"/>	Attention Disorders (ADD/ADHD)					
<input type="checkbox"/>	Anxiety/Depression					
<input type="checkbox"/>	Ear/Eyes/Nose/Sinus problems					
<input type="checkbox"/>	Fainting Spells or Dizziness					
<input type="checkbox"/>	Head Injury/Concussion	Date of injury/concussion:				
<input type="checkbox"/>	Kidney/Bladder Conditions					
<input type="checkbox"/>	Migraines or Severe Headaches					
<input type="checkbox"/>	Mobility Problems or Restrictions					
<input type="checkbox"/>	Muscle or Bone Conditions					
<input type="checkbox"/>	Skin Conditions (Eczema, Psoriasis)					
<input type="checkbox"/>	Stomach/Digestive Problems					
<input type="checkbox"/>	Vision Concerns	Wears: <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts Date of last professional eye exam:				
<input type="checkbox"/>	Hearing Concerns	Right ear <input type="checkbox"/> Left ear <input type="checkbox"/> BOTH ears <input type="checkbox"/> Wears a Hearing Device: No <input type="checkbox"/> Yes <input type="checkbox"/> If Yes, what type of device:				
<input type="checkbox"/>	List any other medical conditions:					
<input type="checkbox"/>	My child will need to have medication at school to be administered on a regular basis or to have as needed. If Yes - Then see below for more information. If Yes, and the medication is prescribed by a doctor, a doctor's order to administer the medication at school is needed annually. If Yes, and the medication is over the counter, an Over The Counter form with a parent/guardian signature is needed. You must supply the medication & label with student name.					
<input type="checkbox"/>	I would like to schedule a meeting with the school nurse to discuss a particular health concern. Indicate your concern(s):					
Printed Name of person who completed this form: _____ Date: _____						