EDEN VALLEY - WATKINS EAGLES

STUDENT HEALTH INFORMATION FORM

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

Student First Name: **Last Name:** **Date of Birth:** **GR:** **Gender:** ☐M ☐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.

☐ 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.)

☐ 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
☐	*Returning Students Only:* Nothing has changed since the previous school year.	
☐	Diabetes	
☐	Seizures	
☐	Allergies (please list them)	Is an EpiPen or Benadryl needed at school?: ☐No ☐Yes Allergic to:
☐	Special Diet OR Food Restrictions	
☐	Asthma	History of: ☐ OR Current: ☐ Will an inhaler be needed at school?: ☐No ☐Yes
☐	Lung/Respiratory Disease	
☐	Heart/Cardiovascular Disease	
☐	Attention Disorders (ADD/ADHD)	
☐	Anxiety/Depression	
☐	Ear/Eyes/Nose/Sinus problems	
☐	Fainting Spells or Dizziness	
☐	Head Injury/Concussion	Date of injury/concussion:
☐	Kidney/Bladder Conditions	
☐	Migraines or Severe Headaches	
☐	Mobility Problems or Restrictions	
☐	Muscle or Bone Conditions	
☐	Skin Conditions (Eczema, Psoriasis)	
☐	Stomach/Digestive Problems	
☐	Vision Concerns	Wears: ☐Glasses ☐Contacts Date of last professional eye exam:
☐	Hearing Concerns	Right ear ☐ Left ear ☐ BOTH ears ☐ Wears a Hearing Device: No ☐ Yes ☐ If Yes, what type of device:
☐	List any other medical conditions:	

☐ **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.

☐ **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: _____