

ANNUAL HEALTH CENSUS FORM

TO BE RENEWED EACH SCHOOL YEAR

STUDENT INFORMATION

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____ School Year: _____

Name of Health Care Provider: _____ Clinic: _____

HEALTH CONDITIONS

___ Asthma ___ Life-threatening Allergy ___ Seizures ___ Diabetes ___ Mental Health ___ Shunt/Implant Device

Other ___ Explain: _____

Vision Concerns: Yes ___ No ___ Explain: _____

Hearing Concerns: Yes ___ No ___ Explain: _____

- *If your student has a health condition you will need to complete an "Emergency Care Plan" which is available on the Health Service page of the district website at isd77.org.*

Would you like to schedule a conference with the licensed school nurse to discuss a particular health concern? YES ___ NO ___

MEDICATIONS

Is the student taking any medication(s)? YES ___ Name of medication: _____ NO ___

Will the student take medication(s) at school? YES ___ NO ___

- *All prescription and nonprescription medications at school require a signed "Consent for Administration of Medication" form, which is available on the Health Service page of the district website at isd77.org.*
- ***All medication must be brought to school by a parent/guardian.***

PARENT/GUARDIAN AUTHORIZATION

- Not providing complete and accurate information may result in an incomplete health and safety plan for your student. The information provided will only be shared with appropriate school staff to meet your student's health and safety needs while at school.
- If your student rides the school bus, it is your responsibility to inform the bus company of your student's health condition and plan.
- If your student participates in before and/or after school activities, it is your responsibility to inform them of your student's health condition and plan.

Consent to share immunization information: *I authorize MAPS to release my child's immunization record to the public health immunization registry (MIIC). I understand this information can only be used to improve the quality and timeliness of immunization services and to help school enforce the Minnesota Immunization Law. This includes any immunization information the school currently has plus any it may obtain during the school year.* YES ___ NO ___

Parent/Guardian signature: _____ Date: _____

(Please print form to sign OR type first and last name)