

Crookston Public School District #593

Health Information Sheet: Parent/Guardian's Report

Student's Name: _____ Birthdate: ____/____/____ Grade: _____

Parent/Guardian's Name: _____

Phone (H): _____ (W): _____ (C): _____

Address: _____ City: _____ Zip: _____

Physician: _____ Clinic: _____ Phone: _____

EMERGENCY CONTACT (if parent is unavailable): Name: _____

Phone: _____ Address: _____ City: _____ Zip: _____

YES	NO	PROBLEM	IF YES, EXPLAIN
		Vision Problem: Glasses or Contacts	
		Hearing Problems	
		Allergies: To What? Type of Reaction?	
		Frequent Stomach Aches	
		Heart Problems (Ex: Murmur)	
		Skin Problems	
		Bladder/Bowel Problems	
		Bone, Joint, or Muscle Problems	
		Diabetes	
		Lung Problems (Ex: Asthma)	
		Epilepsy or Seizures	
		Surgeries or Hospitalizations	
		Mental Health (Ex: Depression, Anxiety, etc.)	
		Behavior Concerns (Ex: concerns, ADHD, etc.)	
		OTHER Health Concerns:	

*The items in **RED** will need additional paperwork completed each school year. The School Nurse will send you the forms.

Does your child take any medication? Yes No

If medications are to be given in school, please complete the **Medication Consent Form**. This form is **REQUIRED** for all medications taken at school including prescription and over the counter meds and must be signed by **BOTH** the **medical provider** and the **parent/guardian**.

I agree to allow the above information to be shared with teachers and staff in order to provide comprehensive care to my student.

Parent or Guardian's Signature: _____ **Date:** _____

Thank you for completing and returning these forms. Please let me know if you have questions or concerns regarding your child's health.

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 Crookston Public School District
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