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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