Health Information Form for The Journey School
K-8

Please return this form to the School Office

Student Name: _____ **Birth Date** _____ **Gender**_____
First Middle Last

Grade/Room _____ **School attended last year if different:** _____

Dear Parent/Guardian:
A student's health may affect his or her learning. Therefore, health information is important in planning for the student's needs at school and in the case of a medical emergency. Health information from this form may be shared with other school staff as needed unless you notify the school that you do not wish this health information shared. This information may also be used as part of the Special Education health assessment. The school nurse assigned to the nonpublic school may contact you for further information if needed. Thank you,

Natasha Hollowell, Licensed School Nurse serving The Journey School Phone: 612-389-1579 K-8 School Year: 2026-27

☐ ***My child has <u>No</u> Health Concerns*** (go to bottom of page AND see second side)

Please put a ✓ if the student has any of these health concerns:

☐ ADHD/ADD

☐ Allergies (to what?) _____

☐ Asthma or other breathing problems
- a. Has the student ever been diagnosed by a **doctor** as having asthma? ☐ Yes ☐ No
- b. Has the student had episode(s) of wheezing (whistling in the chest) in the last 12 months? ☐ Yes ☐ No
- c. In the last **12 months** have you heard the student wheeze or cough after active playing? ☐ Yes ☐ No
- d. Other breathing problem (describe)

☐ Bladder problems/ Bowel problems (describe) _____

☐ Chickenpox (List month and year he/she had disease) _____

☐ Diabetes: ❒ Type 1 ❒ Type 2 Managed by: ❒ Diet only ❒ Oral meds ❒ Insulin injections ❒ Insulin pump

☐ Heart Problems (describe) _____

☐ Is the student pregnant? Due date _____ Does the student have children? Age of child(ren) _____

☐ Seizures: Type (describe) _____ Date of last seizure: _____

☐ Social/emotional/behavioral/mental health concerns (describe) _____

☐ Other health concern or significant history of problems (describe) _____

☐ Activity restrictions: (describe) _____

Any recent surgeries or hospitalizations? ☐ Yes ☐ No If yes, explain:

_____

<u>EMERGENCIES</u>: Does the student have a health problem that could result in an emergency? ☐ Yes ☐ No
If yes, describe: _____

<u>MEDICATIONS:</u> List **<u>ALL</u>** medications that the student takes every day or when needed. A separate consent is **<u>REQUIRED</u>** for **<u>ALL</u>** medication taken at school, including over the counter medications. **The consent must be signed by both <u>HEALTH CARE PROVIDER</u> and <u>PARENT</u>. *<u>A new consent is needed each school year</u>*.** Forms are available in the office.

8:7

Please Turn Over and Complete Back Side

Medication Name Purpose Dose How often taken?

_____

_____

Vision

☐ **No vision problem**

- ☐ Glasses/contacts prescribed
- ☐ Wears glasses/contacts all of the time
- ☐ Wears glasses for reading/computer only
- ☐ Glasses lost/broken
- ☐ Has (or has had) glasses but does not wear
- ☐ Other (describe) _____

Hearing

☐ **No hearing problem**

- ☐ Frequent ear infections (more than 3 per year in past year)
- ☐ Has ear tube(s) Date inserted _____
- ☐ Hearing loss ☐ right ear ☐ left ear
- ☐ Hearing aid(s) ☐ right ear ☐ left ear
- ☐ Aids lost/broken
- ☐ Has (or has had) aids but does not wear
- ☐ Other (describe) _____

Comments: Use this space to describe problems listed or any help you want/need.

HEALTH INSURANCE:

☐ The student has health insurance:

☐ Medical Assistance ☐ Minnesota Care ☐ Assured Care ☐ Other (for example through work)

☐ The student has no health insurance

HEALTH CARE PROVIDERS:

Does the student have a doctor or clinic where they usually go for health care? ☐ Yes ☐ No

Name of Doctor or Clinic	Location and Phone in Case of Emergency	Approximate Date of Last Exam
Primary Health Provider (regular doctor)		
Eye Specialist		
Ear Specialist		
Other Specialist (specify type):		

Hospital preference: _____

Parent/Guardian signature: _____ Daytime phone: _____

Print Parent/Guardian name: _____ Date: _____
(month-day-year)

Parent/Guardian e-mail contact: _____