Student Health Summary - Proctor Public Schools

(complete and return to school)

STUDENT NAME_____GRADE_____DATE OF BIRTH_____

Part 1

Please check if your student has any of these health conditions:

VISION_____(last exam date)_____ HEART _____ CANCER_____EARACHES_____

MENTAL HEALTH_____ HEARING_____ MIGRAINES_____ SEIZURES_____

DENTAL_____**Please list any other health conditions here**: _____

Part 2

Please list **ALL** medications that are currently prescribed to your child. (daily and as needed medications)

MEDICATION_____Dose_____Time given_____Reason_____

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Is medication required during the school day? Yes or No (circle)

***If Yes* you will need to request a Medication Administration form from the School Nurse.**

Part 3

Please check ALL that apply. Provide as much information as necessary for your child to be safely cared for during the school day. Contact the School Nurse with questions/concerns.

- **ALLERGIES** – YES or NO Circle any of the following that apply.

  Bee sting Food Medication Other_____

  How is this allergy managed_____Medication required_____

  ***Please contact the School Nurse to submit an Allergy Action Plan.**

- **ASTHMA**– YES or NO ***Please contact the School Nurse to submit an Asthma Action Plan**

  Type_____Triggers_____

  How is asthma managed_____(ie.inhaler/nebulizer)

- **DIABETES** – YES or NO ***If Yes* Diabetic Management plan required by Doctor***

- **HOSPITAL PREFERENCE** (circle) St. Luke's or Essentia Health

If your child has a health condition and rides the bus to or from school. This information will be shared with the Transportation Dept. and other school officials as needed unless you OPT out.

☐ **Check this BOX to Opt OUT**