



ISD 622 Health Services
Health & Emergency Information
(2024-2025)

Please return
this form to the
Health Office

Student: _____ Grade: _____
____ Gender: _____ Birthdate: ____/____/____ Last First MI
Primary Address: _____ Phone: _____

Dear Parent/Guardian:

A student's health may affect his or her learning. Therefore, updated health information is important. The following information will be held in confidence and disclosed to school personnel to the extent necessary to protect the health and safety of the student. This form should be completed each school year. Please complete this form and return it to the school Health Office as soon as possible.

Thank you
ISD 622 Health Services

HEALTH INFORMATION

Health Concerns

Please put a ✓ if the student CURRENTLY HAS or HAS HAD IN THE PAST any of these health concerns:

- **No Health Concerns**
- Allergies (if yes, to what): _____
 - Anaphylactic/Life threatening? **Yes** *Needs care plan **No**
- Asthma or breathing problems (if yes, see below):
 - Episode(s) of wheezing in the last 12 months? **Yes** *Needs care plan **No**
 - Has the student had to take medication to resolve breathing problems in the last 12 months?
 Yes *Needs care plan **No**
- Bladder/Bowel problems (if yes, describe): _____
- Diabetes (if yes, see below): *Needs care plan
 - Type (I or II): _____
 - Managed by: Diet only Oral medication Insulin injections Insulin pump
- Diagnosed diet restrictions/needs (if yes, describe): _____
- Heart problems (if yes, describe): _____
- Seizures (if yes, see below): *Needs care plan
 - Type (describe) _____ Date of last seizure: _____
- Social/Emotional/Mental Health concerns (if yes, describe): _____
- Recent surgeries or hospitalizations (if yes, describe): _____
- Activity restrictions (if yes, describe): _____
- Other: _____

Complete for High School Students Grades 9-12

According to MS 121.222 (2005) a secondary student may possess and use non-prescription pain relief such as Tylenol or Motrin. Medications must remain in the original container and taken according to directions. Parent/Guardian permission must be given in order for students to "self-carry" non-prescription pain relievers.

- I hereby give my child permission to "self-carry" non-prescription pain relievers.

Signature: _____

Parent(s)/Guardian(s) Note: The school district does not supply over-the-counter pain relievers to students.

Health Insurance

The student HAS health insurance

The student DOES NOT HAVE health insurance. Would you like assistance with applying? **Yes** **No**

Health Care Providers

Primary Care Provider	Clinic/Location	Phone Number

Hospital Preference	Address	Phone Number

***Note:** In case of an emergency, our procedure will be to attempt to contact the parent/guardian. Paramedics or local police may be called for assistance. Your student will be taken to the most appropriate hospital for emergency care if no other arrangements have been made.

Emergency Contacts

Parent/Guardian 1: _____ Print
Name Primary Phone Number Work Phone Number

Email Address

Parent/Guardian 2: _____ Print
Name Primary Phone Number Work Phone Number

Email Address

Emergency Contact: _____ Print
Name Relationship Phone Number

Emergency Contact: _____ Print
Name Relationship Phone Number

Custody Issue **Yes** **No**

***Note:** If custodial issues are involved, a copy of decree must be on file at school.

This information is current and correct. I understand that it is my responsibility as the parent/guardian to notify the school of new or existing health concerns or any changes to contact information. I understand that this health history form must be updated every school year.

Parent/Guardian Signature

Printed Name

Date