LUVERNE PUBLIC SCHOOLS
RETURN TO SCHOOL
HEALTH OFFICE

ANNUAL HEALTH INFORMATION
2009-2010 School Year

NAME:____ SEX: Male Female

BIRTH DATE:_________________ GRADE ENTERING THIS YEAR:______

HEALTH CONCERNS: Please check if your student is subject to the following conditions:

___VISION PROBLEMS___Glasses Prescribed ___Wears glasses/contacts full time___ For classroom only

		Check which ear(s) affected Right	Left	
___EAR/HEARING PROBLEMS (check all that apply)	___Frequent ear infections	___	___	
	___Hearing loss	___	___	
	___Has ear tubes	___	___	Date tubes inserted:__________
	___Wears hearing aid	___	___	

___ALLERGIES:(To what?)____________________________ ___ASTHMA ___DIABETES

___HEART DISEASE ___SEIZURES___BLADDER /BOWEL PROBLEMS___MENTAL HEALTH ISSUES

COMMENTS: Explain items checked above and how school staff should handle any problems.

MEDICATIONS: Please list the medications your student takes either daily or occasionally.

Medication Name	Purpose	Dosage	How often taken?

*School District Policy states that any student taking prescription medication during the school day must have a written consent form signed by the parent/guardian and physician/licensed prescriber. The medication must be in the original pharmacy container. The consent forms may be obtained from the Health Office or www.isd2184.net.

EMERGENCIES: Does your student have a health problem which could result in an emergency? __yes ___no

If yes, describe:____
In case of emergency, if you can not be reached, who shall be called?

Name:____ Phone:_______________________

MEDICATION CONSENT:

The Luverne Schools has acetaminophen (generic Tylenol) and ibuprofen (generic Advil) available for students with complaints of headache and/or muscle aches. Written parent/guardian permission must be on file for students to receive acetaminophen or ibuprofen at school, by signing this form the parent/guardian gives consent for acetaminophen or ibuprofen to be given by the school nurse or her designee.

____ ________________ _______________
Signature of parent/guardian Daytime Phone # Date

________________ ________________
Home Phone # Cell Phone #

The school district intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested personal information. If this form is not completed it may result in an incomplete health and safety plan for your child. The information you provide will be shared only with staff in the school district whose jobs require access to this information to ensure your child's safety and school success. Debrah Vander Kooi, R.N. Licensed School Nurse