

Shakopee Public Schools Annual Student Health Update

Each year the District must update student's health records to ensure that Health Services staff is providing proper services and to ensure that immunizations are up to date. Please return this form to your child's school as soon as possible. If you have any questions, please call the Health Office at 952-445-3387 X135.

Student's Name: _____ **Date of Birth:** _____ **Sex:** Male Female

School: **Shakopee Area Catholic School** **Grade:** _____ **Date:** _____

| Individual Student Health Information & Update | Yes | No |
|---|-----|----|
| 1. Does your child have a medical diagnosis? What is the diagnosis? _____ | | |
| 2. Has your child received any immunization in the last year that has not already been reported to school? Type of Immunization _____ Date _____ Name of Clinic _____ | | |
| 3. Has your child been seriously ill or hospitalized since the last school year? Specifically _____ If yes, is he/ she still under care of a physician? _____ | | |
| 4. Are there health services needed in school? The services needed are: _____ | | |
| 5. Does your child have allergies? Does your child have food allergies? If yes, allergic to what? _____ What is the typical reaction? _____ Should medication be stored at school? _____ When should the medication be used? _____ | | |
| 6. Does your child have asthma? What medications are used? _____ | | |
| 7. Is your child taking any medication on a regular basis? If yes, please name medication and reason: _____ Does this medication need to be administered at school? (If yes, please complete a "Permission to Dispense Medication" available in the office of your child's school. | | |
| 8. Has your child had any vision problems? If yes, please explain _____ | | |
| 9. Has your child had any hearing problems? If yes, please explain _____ | | |
| 10. Does your child have any dietary restrictions/ needs? If yes, please explain _____ | | |
| 11. Does your child have any restriction on physical activity? If yes, please explain _____ | | |
| 12. Would you like an individual meeting with the school nurse? When would you like to have this meeting? _____ | | |

Parent Name (print) _____

Parent Signature _____

Daytime phone _____

Cell phone _____

E-mail address (optional) _____