HEALTH INFORMATION FORM
KASSON-MANTORVILLE ELEMENTARY SCHOOL

604 16th St. N.E. • Kasson, MN 55944-1610 • Phone: 507-634-1234 • Fax: 507-634-1240

Clear Form

Print Form

_____ _____ _____ _____

Student's Last Name Student's First Name Grade Teacher

This information will assist the teacher and the school nurse in meeting the health and education needs of your child. Please complete and return to your school nurse as soon as possible.

Please check any conditions, which apply to your child.*

	Yes	No		Yes	No
Allergies - specify	◯	◯	Hearing Impairment	◯	◯
Asthma	◯	◯	Headaches-Freq. Severe	◯	◯
Bee Sting Allergy	◯	◯	Orthopedic Condition	◯	◯
Convulsive Disorder	◯	◯	Special Diet	◯	◯
Diabetes	◯	◯	Vision Impairment	◯	◯
Emotional Problems	◯	◯	Weight Concerns	◯	◯

*If yes to any of the above, please describe the condition and its current care:

_____

If your child is under medical care at this time, please explain.

_____

List any medications your child takes routinely or frequently.

_____

Specify any restrictions on your child's physical activity

_____

Has your child had any serious illness, accident, or surgery during the past 3 years?

Specify: _____

Indicate if your child has glasses ·_____ Are they to be worn at school? ·_____

Would you like a conference with the School Nurse? ◯ Yes ◯ No If yes, the nurse will call you to schedule an appointment. Daytime telephone number _____

Additional information you care to share.

_____

This information may be shared with staff that has the need to know.

_____ _____

Parent/Guardian's Signature Date