Moose Lake Community School
4812 County Road 10
Moose Lake, MN 55767
T: (218) 485-4435 ext. 1114
F: (218) 351-1295
naomi.mowers@isd97.org

STUDENT HEALTH SUMMARY

Child's Name _____ Date of Birth _____

Parent / Guardian Name _____ Phone _____

HEALTH HISTORY

Medical Diagoses / Health Conditions _____

_____

Allergies _____

Recent or Major Hospitalizations / Surgeries _____

_____

Immunization Status (check all that apply):

- ☐ Up to date on all immunizations
- ☐ Partially up to date on immunizations
- ☐ Medical exemption for all or some immunizations
- ☐ Non-medical exemption for all or some immunizations
- ☐ Other _____

CURRENT HEALTH STATUS

Please complete the following information if your child has any of the conditions listed:

CONDITIONS	SPECIFIC INFORMATION ABOUT MY CHILD'S CONDITION	EMERGENCY MEDICATION OR TREATMENT PRESCRIBED?	EMERGENCY PLAN REQUIRED FROM PHYSICIAN / PROVIDER
☐ Diabetes Type 1 ☐ Diabetes Type 2			Diabetes Medical Management Plan
☐ Asthma			Respiratory Control Plan or Asthma Action Plan
☐ Epilepsy / Seizures			Seizure Treatment Plan
☐ Anaphylaxis			Anaphylaxis Emergency Care Plan

Other health condition that can result in an emergency _____

Other health problem that could interfere with learning _____

Does your child have an Individualized Healthcare Plan (IHP), Emergency Care Plan (ECP) or a 504 Plan from another school or facility? ☐ Yes ☐ No

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To the best of your knowledge, does your child have any current or past health problems that may affect learning in school, cause any concern or be important for school staff to be aware of?

	YES	NO	COMMENTS
ADHD or attention concern			
Allergies & Anaphylaxis			
Arthritis			
Asthma			
Autism			
Behavior concern			
Cancer			
Cardiovascular condition			
Cerebral Palsy			
Chemical or substance use			
Congenital abnormality or Genetic disorder			
Developmental or growth			
Diabetes			
Ear or hearing			
Endocrine			
ENT & Oral / Dental			
Eye or vision			
Gastrointestinal			
Genitourinary			
Headaches or migraines			
Hematology or bleeding			
Immunity			
Infectious disease			
Juvenile arthritis			
Mental health			
Mobility or movement			
Musculoskeletal			
Neurological or head injury			
Nutritional or eating concern			
Obesity			
Pregnancy			
Respiratory or lung concern			
Seizures & Epilepsy			
Skin disorder			
Sleep disturbances or disorder			
Social-Emotional concern			
Speech			
Other			

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Please list any medications or treatments that are prescribed to your child. If medication is required during the school day, a *Medication Order for Administration in School* form must be completed.

MEDICATION / TREATMENT	DOSE	REASON	WILL MEDICATION BE ADMINISTERED AT SCHOOL?

SCHOOL SETTING

Dietary considerations at school_____

Special health treatments or procedures (e.g., tube feeding, catheterization, tracheostomy care)

_____

Adaptive equipment or supplies needed at school _____

Self care skills _____

Activity limitations _____

Other information _____

The School Nurse may contact you for further information or clarification, if indicated.

Individualized Healthcare Plans, Emergency Care Plans and/or 504 Plans may need to be created for students in the following situations:

- Significant or rare medical conditions
- High-level medical or nursing skills required
- Emergency medication or treatment required at school
- Health conditions that significantly impact academic success or attendance

Feel free to contact the School Nurse with any questions or concerns.

Parent Signature: _____ Date: _____