

**St. Ansgar Community Schools
Health Information**

(Please fill out one for each child.)

STUDENT'S NAME _____ GRADE _____

PARENTS/GUARDIAN _____ (Home Phone) _____

MOM'S WORK # _____ Cell # _____

DAD'S WORK # _____ Cell # _____

Siblings also enrolled in St. Ansgar School

Name _____ Grade _____

Name _____ Grade _____

Name _____ Grade _____

IN CASE WE ARE UNABLE TO REACH YOU, PLEASE INCLUDE 3 NAMES OF PEOPLE THAT CAN BE REACHED DURING SCHOOL HOURS:

1. Name _____ Relationship to Child _____ Number _____

2. Name _____ Relationship to Child _____ Number _____

3. Name _____ Relationship to Child _____ Number _____

Name/Address of Child's Doctor _____

Name/Address of Child's Dentist _____

Does student have: Private Insurance ___ Medicaid ___ No Insurance ___ Other ___

If student's health care/dental provider is not available, may we send him/her to another local provider? Yes _____ No _____

In case your child is ill or injured at school or during a school event out of town, and we think he/she needs medical/dental attention, do you grant school personnel and/or the above person(s) permission to do so?

Yes _____ No _____

I give my child permission to receive **Tylenol/Acetaminophen or Ibuprofen** for complaints of discomfort at school from the school nurse and office staff at their discretion for this school year.

Yes _____ No _____

OTC MEDICATION: I give permission for the use of topical antibiotic ointment, cough drops, tums, contact solution, ointment for canker sores, hydrocortisone cream, Benadryl, and caladryl, as needed by the discretion of the health office staff.

Yes _____ No _____

(Continue on backside.)

Does your child have allergies? Please list _____
Typical reaction _____

Is your child taking any medications? Please list _____

Reason for medication _____

I understand that my child can receive medications at school through School Health Services. I understand that the medication must be in the original container with all the information current to what the child receives. I Understand that the medication permission form must be signed and accompany the medication. Ritalin and like drugs must be delivered to school by you, the parent/guardian, or another adult, NOT by the student.

Do you have any health concerns/new information regarding your child for this school year?

Does your child have behavioral/emotional concerns we should be aware of? _____

Has your child experienced any recent changes (divorce, death of a loved one, etc)?

Please check those that may apply to your child:

Glasses/Contacts _____ last eye exam _____

Orthodontist _____

ADD/ADHD _____

Headaches _____

OCD _____

Asthma _____

Hearing Loss _____

ODD _____

Anxiety _____

Heart Disease _____

Scoliosis _____

Depression _____

Kidney Disease _____

Seizures _____

Diabetes _____

Other _____

--Please share this information with the teachers and staff that work with my child.

Yes _____ No _____

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

If you have any other health concerns please feel free to contact me.

Thank you,
Michelle Caron, RN,
St. Ansgar Schools District Nurse
mcaron@stacsd.org