# Nevis Public Schools-------Annual Health Information 2023-2024

Student Name: _____ Birth Date: _____ Grade: _____
Last First Middle Initial

HEALTH CONCERNS: **Please check all that apply.**

- ☐ ADHD ☐ADD ☐Other learning disabilities_____
- ☐ Allergies (list)_____Treatment:_____
- ☐ Food Intolerance (describe)_____
- ☐ Asthma or other breathing problems (describe)_____
- ☐ Bladder problems/Bowel problems (describe)_____
- ☐ Diabetes: Type 1___ Type 2 ___ Managed by (circle): Diet only Oral Meds Insulin injections Insulin pump
- ☐ Heart problems (describe)_____
- ☐ Seizures: Type (describe)_____
- ☐ Anxiety disorder
- ☐ Depression
- ☐ Social/Emotional/Behavioral/Mental health concerns (**circle and describe below**)
- ☐ Vision deficit that requires preferential seating
- ☐ Hearing deficit that requires preferential seating
- ☐ Other health concerns or significant history of problems (describe)_____
- ☐ Activity restrictions (describe)_____
- ☐ Surgeries or hospitalizations in the last year. Explain:_____
- ☐ History of COVID-19 and date of positive test: _____
- ☐ **NO HEALTH CONCERNS**

EMERGENCIES: Does your child have a health problem that could result in an emergency (please circle) YES or NO

If yes, describe:_____
_____

MEDICATIONS TAKEN EVERY DAY OR WHEN NEEDED:

Please list ALL medications that your child takes.

| Medication Name | Reason | Dose | How often taken? |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**If your child needs to take medication at school, please consider the following:**

1. The Authorization for Medication Administration form is REQUIRED for all prescribed medication(s) taken at school.
2. It must be signed by both parent and health care provider. A new consent is needed each school year.
3. Forms are available in the health office and on the Nevis Public School website www.nevis.k12.mn.us.

Over-the counter medication must be brought to the school in the original container with written instructions from the parent and given to the school nurse to administer. Prescription medication must be brought to the school by parent.

***Acetaminophen and ibuprofen are the only medication provided by the school. I give permission to the school nurse to give (in the appropriate dose if necessary): Acetaminophen (Tylenol) or ibuprofen (Advil) Yes_____ No_____**

Students in **Grades 6-12** may self-administer Tylenol/Ibuprofen with the SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION form filled out and signed on the back of this form.

**Is there any other information that might be helpful for us to know about your child or circumstances at home that could affect him/her at school?**

_____

_____ ___/___/___
*Parent/Legal Guardian Signature* *Date*

# *6th Grade and up only*

## *SELF ADMINISTRATION OF MEDICATION AUTHORIZATION*

*Parent/Legal Guardian's Request and Authorization for Self Carry/Self-Administration*

*I, request and authorize my child* _____ *to carry and/or self-administer their medication:*_____

*(Non-prescription pain-reliever, ie. Tylenol, ibuprofen,Tums).*

*This authorization is given based on the following:*

- *My child is capable of and has been instructed in the proper method of self-administration of this medication.*
- *I understand that my child shall be permitted to carry at all times their medication as long as they do not endanger him/herself or other persons, and will not misuse the medication.*
- *I understand that if my child misuses by not taking the prescribed dosage, or endangers other students with the medication, school employees or agents may confiscate the medication.*
- *I understand that this authorization shall be effective for this current school year and must be renewed annually.*

_____

*Parent/Legal Guardian Name (PLEASE PRINT)*

_____ ___/___/___

*Parent/Legal Guardian Signature* *Date*