**Return by 8/31/21**

# HEALTH INFORMATION SHEET

*(Confidential)*

Martin County West Schools

**MANDATORY FORM**

Please complete this sheet and return it to one of the MCW offices. Fill in one sheet per family.

| List each MCW Student Below | Grade | Date of Birth | Building Site (JH/HS, Tri, Sher) |
|---|---|---|---|
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**1. What health concerns or problems does your child have? Describe them below:**
Examples: dental, hearing, eyesight, respiratory, heart, kidney, bowel, liver, diabetes, skin, skeletal, nervous, digestive, cognitive, mental health, activity restrictions, social or emotional conditions, head injury, serious illness or infections; List allergies/reactions (medicine, food, environmental); Has your child been seriously ill or hospitalized in the last year? List any health services needed in school.

| Child's Name | Health Concern(s) |
|---|---|
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**2. Does your child have asthma?** NO____YES____ (if taking asthma medication, list meds below on Q #3)
(A doctor's order is needed if your child will be using an inhaler during school hours.)

**3. Does your child take medication at home on a regular basis?** NO____YES____. It is important that we know what your child is taking at home in case there is an emergency at school and your child needs health care.

| Child's Name | Medication | Dose | Reason for taking |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**4. Has your child received any immunizations in the past year?** Please provide documentation of the immunization(s) that your child received to the school nurse.

**By signing the form below, I request that pertinent health information about my child be shared with appropriate school personnel at the discretion of the nurse.**

_____ _____

Parent/Guardian Signature Date

******TURN OVER******

**COMPLETE THE QUESTIONS BELOW *ONLY* IF YOU HAVE A CHILD WITH DIETARY ISSUES/FOOD ALLERGIES**

**Does your child require any special meal or dietary accommodations? ____ YES ____NO**

*If yes, complete questions below AND obtain a SPECIAL DIET STATEMENT (for a Participant *Without* a Disability) FORM from the office or at the following website address:
http://www.education.state.mn.us/MDE/SchSup/FNS/SNP/FoodServOper/SpecDiet/index.html

**Describe and or select the medical or special dietary condition which restricts the participant's diet**:
_____
_____
_____

**PLEASE CHECK:**

**_____ Lactose Intolerance _____ No milk to drink (School will offer lactose-reduced or lactose free milk)**

**_____ Food Intolerance: Foods to avoid:** _____
_____
_____

**Does your child have a physical or mental impairment that substantially limits or affects one or more major life activities (i.e., eating, seeing, hearing) and/or major bodily functions (i.e., digestion, bowel, bladder, immune system, respiratory, endocrine, etc.) ____ YES ____ NO**

*If yes, complete questions below AND obtain a SPECIAL DIET STATEMENT (for a Participant *With* a Disability) FORM from the office or at the following website address:
http://www.education.state.mn.us/MDE/SchSup/FNS/SNP/FoodServOper/SpecDiet/index.html

**Identify your child's disability**: _____

**Identify food allergy that is life-threatening/anaphylactic (considered a disability**): _____
_____

**Identify the "major life activities" affected by the disability**: _____