

**PELICAN RAPIDS JR-SR HIGH SCHOOL
YEARLY HEALTH/ENROLLMENT INFORMATION FORM
2017-2018**

Student's Name: _____ Age _____ Grade: _____ Birthdate: _____
(Last) (First) (Middle)

Mailing Address _____ Home Phone: _____
(P.O.Box, Street, etc.) (City, State, Zip)

Physical Address _____ Male/Female
(If different from mailing address) (circle one)

Mother's Name: _____ Father's Name: _____
 Employed at: _____ Employed at: _____
 Mother's work phone: _____ Father's work phone: _____
 Mother's cell phone: _____ Father's cell phone: _____
 E-Mail Address: _____ E-Mail Address: _____
 Physician's name: _____ Dentist's name: _____

****It is very important to have an alternate contact person in case your child needs to be sent home due to medical reasons and a parent is unavailable.***

Alternate contacts:

Name: _____ Daytime Phone: _____
 Name: _____ Daytime Phone: _____

OTHER CHILDREN IN THE HOME:

<u>Name</u>	<u>Grade (if in school)</u>	<u>Birth date</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

NEW STUDENTS ONLY:

Date Enrolled in Pelican Rapids: _____
 Name of School Last Attended: _____
 Address of School: _____
 Phone Number/Fax of School: _____

Born in the United States? YES / NO (circle one)

How many years have you attended school in the U.S.? _____

Is your student receiving or has your student received special education services? YES / NO (circle one)

Type: _____ IEP on file: YES / NO (circle one)

ALL NEW STUDENTS must have a completed certificate of immunization requirements form. If you do not have the form in your possession, you need to fax it to the school before beginning class. Anyone not complying with this will not be allowed to attend school until these forms are completed. **THIS IS A STATE LAW.**

Office Information: Student No. _____
 MARSS No. _____
 Transportation Code _____

Health:

Has your child been diagnosed with any of the following: _____ Asthma _____ Allergy _____ Depression _____ Diabetes _____ Other Please describe: _____

List any major illnesses, injuries, or operations that have occurred in the last year: _____

Does the student wear:

Glasses: yes _____ no _____; Contacts: yes _____ no _____; Hearing aides: yes _____ no _____

Does the student use equipment such as a wheelchair: yes _____ no _____

Please describe: _____

Has a physician placed any restrictions on the student's activities? yes _____ no _____

Please describe: (ie: swimming, gym, dietary) _____

Does the student's health condition require an emergency drug? yes _____ no _____

Does the student take a medication daily? yes _____ no _____ As needed? yes _____ no _____

Name of medication: _____ Dosage: _____

Will the student require medication during the school day? yes _____ no _____

Parents are required to furnish all medication for their child. The administration of prescription and nonprescription medication in the elementary school requires a completed Medication Authorization form signed by the student’s parent and the physician prescribing the medication. The administration of prescription medication in the high school requires a completed Medication Authorization form signed by the student’s parent and the physician prescribing the medication. Over the counter medication use for secondary students requires written parental/legal guardian authorization on file at the health office. The school health office personnel should be notified of any change in the student's health status during the school year.

Release of Information

It may be necessary at times to share pertinent health information about your child with school staff in order to provide adequate accommodations to promote a positive learning environment. Please notify the school nurse if you have any concerns or specific things you do not want released to staff members. Only necessary information will be released.

Emergency Information

In the case of emergency, Pelican Rapids School personnel will contact the parent at home or at work. If parents cannot be reached, the above designated persons will be called. When this is not possible, an ambulance or police will be called to transport your child to the nearest health care provider or your designated provider.

Parent or Guardian Signature: _____ Date _____

Sharing Immunization Data with Registry

Minnesota law allows for the sharing of immunization information between schools, health care providers, and public health agencies. One way we do this is by each of these entities contributing the immunization records we have to one computer system that is available only to us, called the Minnesota Immunization Information Connection. This system is operated by the Minnesota Department of Health and contains only basic name and address information plus vaccines names and dates. It is used solely to help prevent disease by improving immunization services in our community. The information can only be shared with those entities authorized by Minnesota law (Minn. Stat. §144.3351) to receive it.

I authorize School District 548 to release my child’s immunization record to the public health immunization registry. I understand this information can only be used to improve the quality and timeliness of immunization services and to help schools enforce the School Immunization Law. This includes any immunization information the school currently has on my child plus any it may obtain during the 2017-2018 school year.

I do authorize I do not authorize

Parent or Guardian Signature: _____ Date: ____/____/____

