PELICAN RAPIDS JR-SR HIGH SCHOOL
YEARLY HEALTH/ENROLLMENT INFORMATION FORM
2018-2019

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:

Name	Grade (if in school)	Birth date

NEW STUDENTS ONLY: *(returning students please skip to Health Information)*

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 _____

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Health Information *(all students must complete this portion):*

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____ Explain: _____

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 2018-2019 school year.

□ I do authorize □ I do not authorize

Parent or Guardian Signature: _____ *Date:* _____