STUDENT HEALTH INFORMATION SHEET: WEST FARGO PUBLIC SCHOOLS

Name: ____ Grade: ____________________

Date of Birth: ____________________ Male: ____ Female: ______

Primary Parent/Guardian Name: __________________________ Phone Number: ____________________

Parent/Guardian Name 2: ______________________________ Phone Number: ____________________

Check one:

☐ Have health insurance ☐ No health insurance ☐ Healthy Steps ☐ Caring Program ☐ Medical Assistance

To help assist your child at school, please complete the following and return to the school office.

EMERGENCY: Does student have a health problem which could result in an emergency (food allergy, insect sting, seizure, diabetes, bleeding problem, heart condition, asthma, other)?

☐ Yes ☐ No If yes, please describe: ____

Would you like an Emergency Care Plan on file for your student?

☐ Yes ☐ No If yes, for what health issue? ____

Hospital Preference: __________________ Language spoken in home: __________________________

MEDICATIONS taken regularly at home and/or school, and reason: ____________________________

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If medication or Emergency Care Plan is needed at school, parent must complete school consent form and have it signed by the licensed prescriber. Forms are at the school office or on the West Fargo Public Schools website: www.west-fargo.k12.nd.us

Individual Education Plan (IEP)? ☐ Yes ☐ No Section 504 accommodation plan? ☐ Yes ☐ No

Health History (check yes or no and explain if needed):

Allergies	☐ No	☐ Yes	Specify:	____________
Asthma	☐ No	☐ Yes	List Medications:	____________
Attention Deficit	☐ No	☐ Yes	When diagnosed	____________
Diabetes	☐ No	☐ Yes	Medications:	____________
Emotional concerns	☐ No	☐ Yes	Specify:	____________
Hearing concerns	☐ No	☐ Yes	Describe:	____________
Heart concerns	☐ No	☐ Yes	Medications:	____________
Seizures	☐ No	☐ Yes	Medications:	____________
Special diet	☐ No	☐ Yes	Specify	____________
Vision concerns	☐ No	☐ Yes	Contacts/glasses?	____________

Other physical or mental health conditions which may be a concern at school?

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The undersigned parent or legal guardian and/or eligible student acknowledges that this Health Information Sheet and the content contained therein is an educational record, the disclosure of which is governed by state and federal laws including the Federal Educational Rights & Privacy Act (FERPA). By signing below I give consent 1) to disclose the information contained herein only as authorized by such laws or regulations, and 2) to use such information to create Emergency Care Plans.

Authorized Signature: ________________________________ Date: ____________________________