

# New Prague Area School – Health Services

## Annual Student Health History Update for Grades 1 – 12

**Student's Full Name** \_\_\_\_\_

**School** \_\_\_\_\_

**Grade** \_\_\_\_\_

Thank you for completing this form! It is our mission to maintain your child's health and safety in school. This information may be shared with staff as necessary. Please return this entire form to your child's school. If you have any questions or comments, please call Cheryl Malecha RN, LSN Health Services Director at 952-758-1760.

**Has your child had any changes in his/her health during the past year?** \_\_\_\_\_ no \_\_\_\_\_ yes  
**If yes, describe** \_\_\_\_\_

**Has your child had any contagious disease or surgery within the last year ?** \_\_\_\_\_ no \_\_\_\_\_ yes  
**If yes, describe** \_\_\_\_\_

**Does your child take medication** (including herbal, OTC, and prescription) **on a regular schedule?** \_\_\_\_\_ no \_\_\_\_\_ yes  
\*Medication Administration Form needs to be completed for a student to receive any medication during the school day.  
**Medication** \_\_\_\_\_ **For the treatment of** \_\_\_\_\_

**Has your child received any immunization(s) within the past year?** \_\_\_\_\_ no \_\_\_\_\_ yes  
**Td (mo/day/yr)** \_\_\_\_\_ **MMR (mo/day/yr)** \_\_\_\_\_ **Hep. B (mo/day/yr)** \_\_\_\_\_  
**Other (mo/day/yr)** \_\_\_\_\_ [(mo/day/yr) required per Mn Statute 121A.15]

**Is your child able to participate in regular physical education?** \_\_\_\_\_ no \_\_\_\_\_ yes  
**Limitations/concerns** \_\_\_\_\_

**In order to better maintain your child's health & safety, please check any or all areas of concern:**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Allergies             <ul style="list-style-type: none"> <li>— Bee sting (mild or severe)</li> <li>— Food _____</li> <li>— Hayfever/Seasonal</li> </ul> </li> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Emotional/Behavioral             <ul style="list-style-type: none"> <li>— ADD(H)</li> <li>— Anxiety</li> <li>— Depression</li> <li>— Other _____</li> </ul> </li> <li><input type="checkbox"/> Epilepsy/Seizures</li> <li><input type="checkbox"/> Headaches             <ul style="list-style-type: none"> <li>— Treated with _____</li> </ul> </li> <li><input type="checkbox"/> Hearing concerns             <ul style="list-style-type: none"> <li>— Wears hearing aid ( L R )</li> <li>— Earaches</li> <li>— Loss of hearing ( L R )</li> </ul> </li> <li><input type="checkbox"/> Injury/Trauma             <ul style="list-style-type: none"> <li>— Head</li> <li>— Other _____</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Heart Condition             <ul style="list-style-type: none"> <li>— Dizziness/Fainting</li> <li>— Other</li> </ul> </li> <li><input type="checkbox"/> Nosebleeds ___ frequent</li> <li><input type="checkbox"/> Sinus Infections ___ frequent</li> <li><input type="checkbox"/> Sore throats/colds ___ frequent</li> <li><input type="checkbox"/> Vision Concerns             <ul style="list-style-type: none"> <li>— Wears glasses</li> <li>— Wears contacts</li> <li>— Other _____</li> </ul> </li> <li><input type="checkbox"/> Stomach concerns             <ul style="list-style-type: none"> <li>— Stomachaches</li> <li>— Ulcers</li> <li>— other</li> </ul> </li> <li><input type="checkbox"/> Weight concern             <ul style="list-style-type: none"> <li>— Gain</li> <li>— Loss</li> </ul> </li> <li><input type="checkbox"/> Other Health Issues             <ul style="list-style-type: none"> <li>— _____</li> </ul> </li> </ul> |
|--|---|



Check here if your child does not have any health concerns.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_