ISD 709 Duluth Public Schools

ANNUAL HEALTH HISTORY (2-sided form)

School Year_____

Name_____ ❒ Male ❒ Female Birthdate ___/___/___ Gr. _____

Parent / Guardian_____Home Ph _____Work Ph _____Cell_____

Parent / Guardian_____Home Ph _____Work Ph _____Cell_____

Physician_____ Phone _____Dentist _____ Phone _____

Hospital Preference _____ School Previously Attended_____

Is student covered by health insurance? ❒Yes ❒No (If yes: ❒ Medical Assistance ❒ Minnesota Care ❒ Private/ employer-provided insurance)

In case of emergency / illness at school and parents can not be reached, call:

Name _____ Phone (H) _____(W)_____(C)_____Call 1st/2nd

Name _____ Phone (H) _____(W)_____(C)_____Call 1st/2nd

***Immunizations* are required by law to attend school.**
Please provide documentation of all immunizations given in the past year.

Allergies:

_____

Current Health Diagnosis/Conditions (physical &/or mental health): (example: Asthma, Diabetes, ADHD)

_____

_____

Serious illness, operation, hospitalization or accidents within the last 12 months:

_____

_____

Medications (at home &/or at school) - provide drug name, dosage & times taken:

_____

_____

When medication is to be taken in school: Contact the School Health Office.

Policy requires that a pharmacy labeled container of the medication be provided, along with written parent/guardian & prescriber permission. Medication forms are available from the school health office. The school is able to fax the provider for permission once parent/guardian signature has been obtained.

*****OVER THE COUNTER MEDICATION AUTHORIZATION PROVIDED ON THE REVERSE SIDE*****

Date of last eye exam: ___/___/___ By Dr: _____ Glasses? ❒Yes ❒No Contacts? ❒Yes ❒No

Reason for glasses: ❒ Nearsighted ❒ Farsighted ❒ Other:_____

Date of last Physical exam: ___ / ___ / ___ By Doctor:_____

Date of last Dental exam: ___ / ___ / ___ By DDS:_____

*X*_____ _____ _____

Parent/Guardian Signature *Please Print Name* *Date*

In order for schools to provide continuity of health care, a health record is kept on file for each child that includes: immunizations, health history, and hearing & vision screenings. Health information may be shared with school staff to insure continuity of care.

DISCLOSURE OF PROTECTED HEALTH INFORMATION

- I may refuse to sign this annual health history and it will not affect my child's ability to receive educational services.
- The laws that protect the information identified on the Annual Health History in some situations may allow or require this entity to disclose this information, but only as permitted by law Health Insurance Portability and Accountability Act (HIPAA) Family Educational Rights and Privacy Act (FERPA), Minnesota Government Data Practices Act (MGDPA) or Chapter 13.

Duluth Public Schools
Independent School District #709
215 North First Avenue East
Duluth, MN 55802-2058

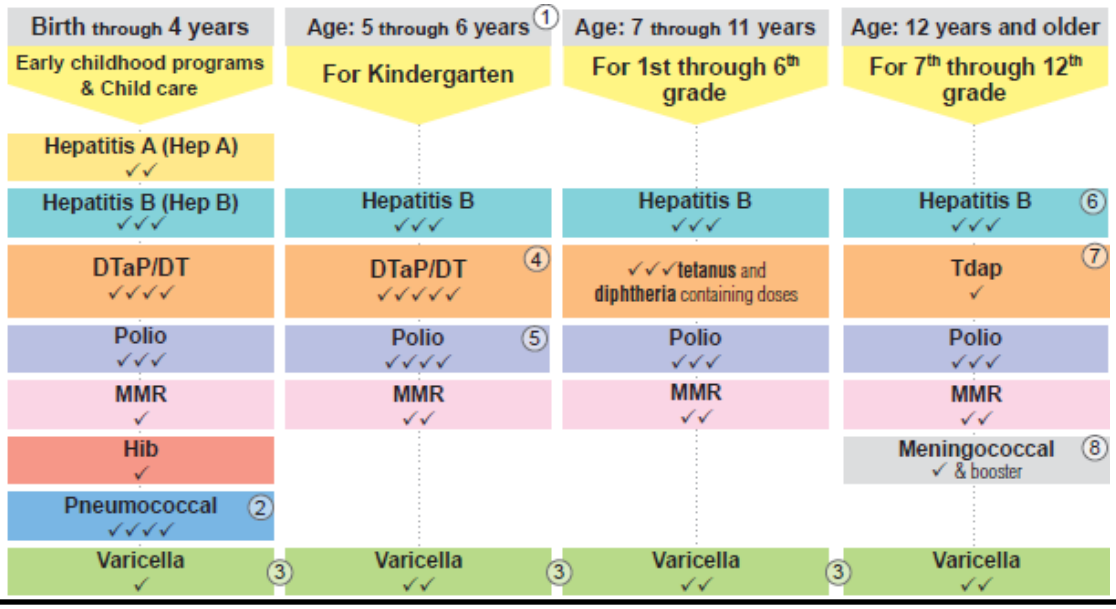
CONSENT FOR RELEASE AND EXCHANGE OF IMMUNIZATION INFORMATION

Minnesota's Immunization Law

Immunization Requirements

Use this chart as a guide to determine which vaccines are required to enroll in child care, early childhood programs, and school (public or private).

Find the child's age/grade level and look to see if your child had the number of shots shown by the checkmarks under each vaccine. Children birth to age 2 may not have received all doses. Look at the table on the back, it shows the age when doses are due.



Student Name_____ D.O.B._____

I authorize:

Duluth Public Schools, ISD 709 Attn: _____ _____
Name of School School Nurse

School Address_____Zip_____

To release/obtain Immunization Records From:

_____
State Immunization Registry and/or Last School(s) Attended (List Previous State of Residence)

I understand that this authorization takes effect the day that I sign it. It expires on _____.
or no more than one year from the date of my signature.

- I also understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand by authorizing use or disclosure of information, there will be no conditions placed on my health care/educational service or payment for my health care/educational service.
- I understand I will receive a copy of this form after I have signed it.
- I understand that in compliance with MN Statute 144.33 and WI Administrative Code HHS117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.
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X_____ Date_____
Parent Signature, or Student if age 18 or older (MM/DD/YYYY)