HEARTLAND CHRISTIAN ACADEMY
Cultivating Faith, Values & Education

Annual Health Information 2021-2022

Grade _____

Please complete this form in its entirety and return to the school health office.

Student Full Legal Name:_____
Last First Middle

Prefered Name:_____ Gender_____ Birth Date_____

Father / Guardian Name_____ Mother / Guardian Name_____

Preferred Emergency Phone #_____ Mom or Dad (Circle Please) Additional # _____

Secondary Emergency Phone #_____ Mom or Dad (Circle Please) Additional # _____

EMERGENCY NAMES

Persons authorized to pick up, care for the student when ill, and/or act in an emergency when parents can not be reached

Name _____ Relation to Student _____

Phone # 1_____ Phone # 2_____

Name _____ Relation to Student _____

Phone # 1_____ Phone # 2_____

HEALTH HISTORY Please check all --that apply.

Health Care Provider or Clinic _____ Phone # _____

Dentist Clinic: _____ Phone # _____

Students Height_____ Weight_____

- ❑ Allergies(list) _____
- ❑ ADHD/ ADD/ Other learning disabilities (list) _____
- ❑ Asthma or other breathing problems: (describe) _____
- ❑ Bladder and/or Bowel Problems(describe) _____
- ❑ Chickenpox (list month and year he /she had disease)_____
- ❑ Diabetes: ☐ Type I ☐ Type 2 Managed by: ☐ Diet only ☐ Oral meds ☐ Insulin injections ☐ Insulin pump
- ❑ Food Intolerance (describe) _____
- ❑ Heart problems (describe) _____
- ❑ Seizures: Type (describe) _____
- ❑ Social / Emotional / Behavioral / Mental health concerns (describe) _____
- ❑ Vision deficit ☐ Wears Glasses ☐ Wears Contacts ☐ Requires Preferential Seating
- ❑ Hearing deficit ☐ Wears Hearing Aids ☐ Requires Preferential Seating
- ❑ Other health concerns or significant history of problems (describe) _____
- ❑ Activity restrictions (describe) _____
- ❑ Surgeries or hospitalizations in the last year. Explain:_____
- ❑ No Health Concerns

EMERGENCIES: Does your child have a health problem that could result in an emergency? ☐ YES ☐ NO

If yes describe:_____

LIST MEDICATIONS TAKEN BY YOUR CHILD EVERY DAY OR WHEN NEEDED

Medication Name	**Reason**	**Dose**	**How often taken**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If your child needs to take medication at school, please consider the following:
1. The Authorization for Medication Administration form is REQUIRED for all medication(s) taken at school, including non-prescription (over the counter) medications. Students must take all medications at school through the health office unless otherwise arranged individually with the licensed school nurse.
2. The Authorization for Prescription Medication Administration form must be signed by both the HEALTH CARE PROVIDER and PARENT. A new consent is needed each school year.
3. Forms are available in the Office and Online.

Is there any other information that might be helpful for us to know about your child's health or circumstances at home that could affect him/her at school? ⬜ YES ⬜ NO If Yes, Please explain _____

_____

_____

KINDERGARTEN, 7TH GRADE and **HIGH SCHOOL** students **MUST** have an updated immunization record turned in with this form.

The Heartland Christain Academy Health Policies will be provided to you in our Student Handbook. Please review these policies and refer back to it if any illnesses arise.

A child MUST be kept home if any of the following:

- Temperature of 100° or more
- Vomiting or Diarrhea - must be symptom free for 24 Hours
- Strep Throat - on Antibiotics for 12 hours
- Whooping Cough - on Antibiotics for 5 days
- 24 hours from start of Antibiotics for other contagious illness unless with a Doctor's note (excludes Ear Infections, Pink Eye, and Above)
- Significant Covid Exposure - remain home until negative covid test
- Positive Covid Test -parents refer to their health care provider for their recommendations
- When in Doubt, keep them home

Permission for Release of Information

I give permission for the school nurse to communicate, as needed, with school staff about my child's medical condition(s) and medications my child is taking.

In the event your child has a severe allergic reaction or goes into anaphylactic shock, Heartland staff will administer epinephrine and call 911.

_____ _____ _____

Parent/Guardian Signature Date Relationship to Student

Heartland school intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested personal information. There will be no consequences for not providing the information. It may result in an incomplete health and safety plan for your child. All medical health records are overseen by Bemidji School District ISD31. The information you provide will be shared only with staff in the school district whose jobs require access to this information to ensure your child's safety and school success.