Registration Information
Osseo Area Schools, ISD 279, Health Services

Student Health History

To Be Completed by Parent/Guardian at the Time of Registration

Student's Name_____ Date of Birth_____Grade _____

Does your student have any chronic health condition? (Circle)

Asthma
ADD/ADHD
Diabetes
Epilepsy/Seizures
Hearing Loss / Hearing Aid
Heart Disease
Scoliosis
Sickle Cell Disease
Tuberculosis
Vision Loss / Corrective Lenses
Emotional/Behavioral Concerns
Other

Explain:_____

_____

_____

Has he/she ever been hospitalized for illness, surgery, or injury? Yes____ No_____
If yes, explain:_____

Does he/she take any medications? Yes____ No_____
If yes, what and when? _____
(Please see the Health Specialist if medications are to be given at school.)

Does he/she have any allergies? Yes____ No_____
To what? (medications, bee sting, pollens, foods, other) _____

Is his/her physical activity limited in any way? Yes____ No_____
If yes, explain_____

Other Comments:_____

_____

_____

This information is requested in order to provide appropriate health services for your student. The data will be treated as private data and will be recorded in the student health record. It will be shared with those working with your student only on a "need to know" basis and with emergency personnel in case of an emergency.

_____ _____
Parent/Guardian Signature Date