Saint Wenceslaus 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 952-758-1413.

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:

- ❑ **Asthma**
- ❑ **Allergies**
  - — **Bee sting (mild or severe)**
  - — **Food _____**
  - — **Hayfever/Seasonal**
- ❑ **Diabetes**
- ❑ **Emotional/Behavioral**
  - — **ADD(H)**
  - — **Anxiety**
  - — **Depression**
  - — **Other_____**
- ❑ **Epilepsy/Seizures**
- ❑ **Headaches**
  - — **Treated with _____**
- ❑ **Hearing concerns**
  - — **Wears hearing aid (L R)**
  - — **Earaches**
  - — **Loss of hearing (L R)**
- ❑ **Injury/Trauma**
  - — **Head**
  - — **Other _____**
- ❑ **Heart Condition**
  - — **Dizziness/Fainting**
  - — **Other**
- ❑ **Nosebleeds ___ frequent**
- ❑ **Sinus Infections ___ frequent**
- ❑ **Sore throats/colds ___ frequent**
- ❑ **Vision Concerns**
  - — **Wears glasses**
  - — **Wears contacts**
  - — **Other _____**
- ❑ **Stomach concerns**
  - — **Stomachaches**
  - — **Ulcers**
  - — **other**
- ❑ **Weight concern**
  - — **Gain**
  - — **Loss**
- ❑ **Other Health Issues**
  - — **_____**

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

Parent/Guardian Signature _____ **Date** _____