

Health History

Student Name _____ DOB _____

Parent/Guardian _____

Phone Number(s): _____

Health Conditions that could impact my child’s learning: such as anxiety, depression, test anxiety, social issues, frequent headaches, chronic stomach issues, frequent heartburn, etc.

Primary Care Physician: _____ Phone Number: _____

Clinic: _____

Medications my child takes routinely and what the medication is for:

Any problems with vision? Yes No

Any problems with hearing? Yes No

Any dietary concerns? Yes No

If Yes, please explain:

Any concerns you might have related to your child’s health and school?

Any question or concerns you would like to speak to me personally about, I can be reached by phone- 218-280-3125 or office- 218-784-5433, or email tracy.johnson@co.norman.mn.us

Sincerely,

Tracy Johnson RN, Licensed School Nurse