# Annual Health Information

**Dear Parent/Guardian:** The information on this form will be used to meet your child's health needs at the school. Please complete all sections of the form and then sign and return it to your child's teacher as soon as possible. Every student must have a new form completed each year.

School Name:

Grade:

Is your child new to the district?
☐ Yes ☐ No

Student's First Name:

Middle Name:

Last Name:

Suffix (Jr., III, etc.)

Date of Birth:
(MM/DD/YYYY)

Parent/Guardian Name:

Relationship to Student:

Home or Cell Phone: (          )

Work Phone: (          )

What type of health insurance does your child have?

☐ Medicaid
☐ Private
☐ Unsure
☐ My child does not currently have health insurance

If your child has Medicaid, please mark the plan name:

☐ Aetna
☐ Blue Cross Complete
☐ HAP Midwest
☐ McLaren
☐ Meridian
☐ Molina
☐ Total Health Care
☐ United
☐ Other

What type of dental insurance does your child have?

Healthy Kids *(please select which plan)*
☐ Blue Cross Blue Shield
☐ Delta Dental
☐ Unsure which Healthy Kids plan

☐ Private

☐ Unsure

## Does your child have any of the following health conditions?

| HEALTH CONDITION | YES | NO |
|---|---|---|
| Severe allergies (food, insects, drugs, latex) | | |

If yes, please state what your child is allergic to (certain foods, insects, latex, etc)

______________________________

______________________________

______________________________

______________________________

If yes, please check the reaction that occurs:

☐ Hives
☐ Swelling
☐ Trouble breathing
☐ Other

| HEALTH CONDITION | YES | NO |
|---|---|---|
| Allergies *(seasonal)* | | |
| Anxiety | | |
| Asthma or breathing problems | | |
| Attention Deficit Hyperactivity Disorder | | |
| Behavioral Problems | | |
| Bladder or Bowel Problems | | |
| Dental Problems | | |
| Depression | | |
| Diabetes | | |
| Head Injury or Concussions | | |
| Hearing Problems | | |

| HEALTH CONDITION | YES | NO |
|---|---|---|
| Heart Problems | | |
| Lead Poisoning | | |
| Pregnant | | |
| Seizures | | |
| Sickle Cell Disease | | |
| Speech Problems | | |
| Vision Problems | | |
| Wears Glasses | | |
| Other Health Conditions, please list: | | |

## MEDICATIONS AND/OR SPECIAL PROCEDURES*

| Question | Yes* | No |
|---|---|---|
| Does your child require any daily medications to be taken at school? | ☐ Yes* | ☐ No |
| Does your child require any emergency medications be kept at school? | ☐ Yes* | ☐ No |
| Does your child require any special procedures to be done at school? *(g-tube feeding, catheterization, etc.)* | ☐ Yes* | ☐ No |

***If you answered yes to any of the above questions under Medications and Special Procedures, please complete the Authorization for Release of Medical Information form. If needed, please have your provider complete the Prescribed Medication form. Both forms are available at detroitk12.org/enrollnow and must be renewed every year.***

## MEDICAL CARE PROVIDERS

| | | |
|---|---|---|
| Doctor's Name: | Phone: ( ) | Address: |
| Date of last physical: (MM/DD/YYYY) | ☐ Unsure | |
| Dentist's Name: | Phone: ( ) | Address: |
| Date of last dental exam: (MM/DD/YYYY) | ☐ Unsure | |

| | |
|---|---|
| Medical Specialist (optional): | Local Hospital: |
| Phone: ( ) | Emergency Room Phone: ( ) |
| Address: | Address: |

## FAMILY NEEDS

In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food? ☐ Yes ☐ No

## ACKNOWLEDGMENTS & SIGNATURE

I certify that this information is correct to the best of my knowledge and understand that it is my responsibility to inform the school if any of this information changes. I also understand that this information may be shared with need-to-know staff at my child's school in order to keep my child safe and protected while at school.

Parent or Guardian Signature ____________ Print Name ____________ Date ____________ (MM/DD/YYYY)

## TO BE COMPLETED BY OFFICE STAFF

| | DATE | STAFF PERSON |
|---|---|---|
| Form received | | |
| Information entered into Student Information System | | |

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