

**STUDENT HEALTH CARE PLAN  
CLARKFIELD AREA CHARTER SCHOOL**

**301 13<sup>TH</sup> Street  
Clarkfield, MN 56223  
Phone 320-669-1995**

STUDENTS NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

PARENTS OR GUARDIANS: \_\_\_\_\_ Grade: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

WORK PHONE (MOTHER): \_\_\_\_\_ CELL: \_\_\_\_\_

WORK PHONE (FATHER): \_\_\_\_\_ CELL: \_\_\_\_\_

EMERGENCY CONTACT #1: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMERGENCY CONTACT #2: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

PRIMARY PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DENTIST: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

**MEDICAL INFORMATION:**

ALLERGIES: MEDICATIONS: \_\_\_\_\_ FOODS: \_\_\_\_\_

OTHER ALLERGIES: \_\_\_\_\_ LATEX ALLERGY: YES \_\_\_ NO \_\_\_

HEALTH HISTORY:--CHECK (X) BY THOSE THAT APPLY

\_\_\_\_ EPILEPSY \_\_\_\_ ASTHMA \_\_\_\_ HEART CONDITION \_\_\_\_ DIABETES \_\_\_\_ HEADACHES

\_\_\_\_ STOMACH PROBLEMS \_\_\_\_ EAR INFECTIONS \_\_\_\_ EYPROBLEMS \_\_\_\_ EYEGLASSES

\_\_\_\_ ADHD \_\_\_\_ OTHER (PLEASE LIST) \_\_\_\_\_

HEALTH CONCERN/DIAGNOSIS: (How presents, triggers, etc.) \_\_\_\_\_

TREATMENT/PRECAUTIONS/PLAN (Interventions, meds, parent notifications, etc.) \_\_\_\_\_

CURRENT MEDICATIONS: PRESCRIPTION: (please list medication/reason for taking/how often) \_\_\_\_\_

NONPRESCRIPTION: (please list medication/reason for taking/how often) \_\_\_\_\_

This information will be shared with teachers and other appropriate staff. If only specific staff, please list who: \_\_\_\_\_

PARENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

SCHOOL NURSE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

