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