2024-2025 Student Health Information

Saint Paul Conservatory for Performing Artists (SPCPA)

LAST NAME:

Student Name: _____ **Birth Date:** _____ **Legal Gender:** _____ **Grade:** _____
Preferred Student Name, Gender, and/or Pronoun Usage Form available in Main Office dd/mm/yyyy

Primary Address: _____ **Phone:** _____
***Have you moved? If so, please check here if this is a new address.** ☐

A student's health may affect learning. Therefore, updated health information is important. The following information will be held in confidence and disclosed to school personnel to the extent necessary to protect the health and safety of your student. This form should be completed and returned to the main office each school year.

HEALTH INFORMATION: Please indicate if your child has any of the following:

Yes	No	
☐	☐	Allergies - If yes, to what? _____
☐	☐	Did a Health Care Provider diagnose the allergy(ies)?
☐	☐	Medication(s) for allergies: _____ ***School will facilitate the completion of an Individualized Health Plan, if appropriate***
☐	☐	Asthma or other breathing problems - please describe other breathing problems: _____
☐	☐	Did a Health Care Provider diagnose the asthma or breathing problems?
☐	☐	Has the student been hospitalization in the last 12 months for asthma or breathing problems?
☐	☐	Has the student had to take medication in the last 12 months to resolve breathing problems? ***School will facilitate the completion of an Individualized Health Plan, if appropriate***
☐	☐	Diabetes: ☐ Type 1 ☐ Type 2 ***School will facilitate the completion of an Individualized Health Plan*** Managed by: ☐ Diet and/or Activity ☐ Oral Medication ☐ Insulin Injections ☐ Insulin Pump
☐	☐	Heart Conditions - please describe: _____
☐	☐	Seizures - date and type of last seizure: _____ ***School will facilitate the completion of an Individualized Health Plan***
☐	☐	Recent surgeries or hospitalizations - please describe: _____
☐	☐	Activity Restrictions - please describe: _____ ***A current written note from a Health Care Provider stating the restrictions and length of restrictions must be provided to the school.***
☐	☐	Other - please describe: _____ ***Use back of form if additional space is needed.***
☐	☐	Will your student need to take medication(s) while at school? ***Parent/Guardian must facilitate the completion of Medication Order and Administration Form***

VISION
☐ Glasses or contacts prescribed
☐ Wears glasses or contacts all day
☐ Wears glasses in classroom only
☐ No vision problem

HEARING
☐ Hearing loss ☐ right ear ☐ left ear
☐ Hearing aid(s) ☐ right ear ☐ left ear
☐ No hearing problem

HEALTH INSURANCE
My child has health insurance: ☐ Yes ☐ No I request assistance with health insurance: ☐ Yes ☐ No

HEALTH CARE PROVIDER
Does your child have a doctor or clinic where they usually go for health care? ☐ Yes ☐ No

Primary Care Provider	Clinic/Location	Phone Number

HOSPITAL PREFERENCE
☐ Children's ☐ Region's ☐ St. Joseph's ☐ United ☐ Most appropriate, as determined by emergency services

This information is current and correct. I understand it is my responsibility as the parent/guardian to notify the school with new or existing health information, as well as any changes. I understand my student's health information must be updated annually.

Parent/Guardian Signature	Printed Name	Date