STUDENT HEALTH CARE PLAN
CLARKFIELD AREA CHARTER SCHOOL

301 13TH 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:_____