DETROIT PUBLIC SCHOOLS COMMUNITY DISTRICT
Students Rise. We All Rise.

ANNUAL HEALTH INFORMATION
2020 - 2021

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 Last Name:	First Name:	Middle Name:	Suffix (Jr., III, etc.)
Date of Birth: / /			
Parent/Guardian Name:		Relationship to student:	
Home or Cell Phone: ( )		Work Phone: ( )	
Health Care Provider Name:		Health Care Provider Phone: ( )	
Date of last physical: / / ☐ Unsure		Date of last dental exam: / / ☐ Unsure	

What type of insurance does your child have?

- ☐ Medicaid
- ☐ Private
- ☐ Unsure
- ☐ My child does not currently have 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

Does your child have any of the following health conditions?

HEALTH CONDITION	YES	NO	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			Depression		
			Diabetes		
			Head Injury or Concussions		
			Hearing Problems		
			Heart Problems		
			Lead Poisoning		
			Pregnant		
			Seizures		
Allergies (seasonal)			Sickle Cell Disease		
Anxiety			Speech Problems		
Asthma or breathing problems			Vision Problems		
Attention Deficit Hyperactivity Disorder			Wears Glasses		
Behavioral Problems			Other Health Conditions, please list:		
Bladder or Bowel Problems					
Dental Problems					

MEDICATIONS AND/OR SPECIAL PROCEDURES*

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 have your child's health care provider complete the attached medication/procedure authorization form. The form must be signed by both the health care provider and the parent, and must also be renewed every year.**

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

TO BE COMPLETED BY OFFICE STAFF

	DATE	STAFF PERSON
Form Received		
Information entered into Student Information System		

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