McDonald County R-1 School District

Student Health Inventory 2018-19

Legal Name: _____ (Last) _____ (First) _____ (MI) Date of birth: _____ Grade: _____

Gender: ◯ Female ◯ Male Teacher (if applicable): _____

Parent/Guardian: _____ Relationship: _____

Work #: _____ Home #: _____ Cell #: _____

Parent/Guardian: _____ Relationship: _____

Work #: _____ Home #: _____ Cell #: _____

Emergency Contacts: _____ (Name) _____ (Relationship) _____ (Name) _____ (Relationship)

Phone #: _____ Phone #: _____

Doctor's name: _____ Date of last well-child exam: _____

Where should your child be taken in case of emergency? _____
(Example: Clinic, ER, Urgent/Express Care)

Dentist's name: _____ Date of last dental exam: _____

Is your child under an orthodontist's care? ☐ Yes ☐ No

Does your child/student have: Private health insurance? ☐ Yes ☐ No ID#: _____ Group #: _____

Medicaid or MO HealthNet for Kids (MHK)? ☐ Yes ☐ No Medicaid #: _____

Prescription Group Plan #: _____ Hospital Preference: _____

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If your child has been prescribed any emergency medication, we ask that you supply the medication to the school nurse and complete the required forms.

Should a child develop an anaphylaxis episode of an undiagnosed or unknown cause, the nurse has prescription epinephrine and albuterol available to use in the event of a life-threatening emergency. If you do not want your child to have this potentially life-saving medication, please contact the nurse and ask for an Opt-Out form to sign.

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Does your child have any of the following health concerns? If yes, please provide details, including restrictions, in the spaces provided.

Allergies	◯ Yes	◯ No	To what? _____ EpiPen? _____
Asthma	◯ Yes	◯ No	Meds needed at school? _____
Diabetes	◯ Yes	◯ No	Type 1 ____ Type 2 ____ Oral meds or insulin? _____
Epilepsy/Seizures	◯ Yes	◯ No	_____
Heart Condition	◯ Yes	◯ No	_____
Bone/Joint Problems	◯ Yes	◯ No	_____
ADD/ADHD	◯ Yes	◯ No	_____
Eyes/Glasses	◯ Yes	◯ No	_____
Ears/Hearing	◯ Yes	◯ No	_____
Nosebleeds	◯ Yes	◯ No	_____
Appetite	◯ Yes	◯ No	_____
Sleep	◯ Yes	◯ No	_____
Bladder/Bowel	◯ Yes	◯ No	_____
Menstruation	◯ Yes	◯ No	_____

Please complete front and back and RETURN TO YOUR SCHOOL NURSE.

Complete the Following Regarding Health Concerns that Pertain to Your Child

Takes **daily** medication? At home ◯ Yes ◯ No If yes, list medications below
At school ◯ Yes ◯ No If yes, list medications below and **notify nurse**
Emergency only ◯ Yes ◯ No List the emergency medication _____

Name of daily medication: _____ Dosage: _____ Times taken: _____

Reason: _____

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Reason: _____

Name of daily medication: _____ Dosage: _____ Times taken: _____

Reason: _____

Check all that apply to your student. Attach additional sheet if more room Is needed.

Eyes: ◯ Glasses ◯ Reading ◯ Distance ◯ Contacts ◯ Crossed ◯ Lazy eye ◯ Other, explain _____

Ears: ◯ Frequent infections ◯ Tubes ◯ Hearing difficulty ◯ Explain _____
◯ Hearing aid ☐ Right ☐ Left Wear at school: ☐ Yes ☐ No

List childhood diseases, serious illness, injuries, and surgeries: _____

Requires special health care, please explain: _____

Other health information or concerns: _____

Special procedures required: _____

If your student requires **routine medication at school**, please obtain the **appropriate forms** in the school nurse office/clinic. Health information will be shared only with the persons listed by the parent/guardian on this form and school staff on a need to know basis.

I hereby authorize the school nurse, or other school personnel designated to administer medications, to administer **acetaminophen** (Tylenol®), **ibuprofen** (Advil/Motrin®), **calcium antacid** (Tums®), **diphenhydramine** (Benadryl®), or other **non-prescription first aid medications**, to my student **with the following EXCLUSIONS:**

DO NOT GIVE: _____

Reason: _____

Additionally, in the case of an emergency, I authorize school staff to share health information with the emergency personnel, physician, surgeon, hospital/medical staff or dentist involved in my child's treatment and understand my child may be transported by medical emergency services. I also authorize any physician, surgeon, dentist or other medical personnel of the nearest medical facility, to administer any emergency treatment, procedure or medicine necessary and advisable. I also authorize the use of an ambulance, if necessary, to transport my child. I further agree to pay for all services provided for my child.

Please list any other specific emergency instructions in the event that you cannot be reached.

_____

X _____ _____
Signature of parent/legal guardian Date

FREEMAN Health System
Neosho Hospital

I authorize any school nurse at McDonald County R-1 Schools to release to Freeman Clinic of Anderson any or all medical records, including this *Student Health Inventory*, on my child/student or myself (if I am an adult or a consenting minor under Missouri law) as needed for treatment or continuity of care.

X _____ _____
Signature of parent/legal guardian Date