NEOSHO SCHOOL DISTRICT

Student Health Inventory 2018-19

Legal Name: ________________________________ Date of birth: ______________ Grade: ________
Last First MI

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

Parent/Guardian: ______________ Relationship: ______________

Work #: ______________ Home #: ______________ Cell #: ______________

Lives with? ☐ Yes ☐ No Contact this parent first: ☐ Yes ☐ No

Parent/Guardian: ______________ Relationship: ______________

Work #: ______________ Home #: ______________ Cell #: ______________

Lives with? ☐ Yes ☐ No Contact this parent first: ☐ Yes ☐ No

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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Does your child have any of the following conditions diagnosed by a provider? If yes, please provide details in the spaces provided.

Allergies to medication ◯ Yes ◯ No Please list ______________ Life-threatening? ◯ Yes ◯ No

Allergies to foods ◯ Yes ◯ No Please list ______________ Life-threatening? ◯ Yes ◯ No

Allergies to insects/bees ◯ Yes ◯ No Please list ______________ Life-threatening? ◯ Yes ◯ No

Have any of the above required emergency action? ◯ Yes ◯ No Epipen? ◯ Yes ◯ No

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Asthma ◯ Yes ◯ No Meds needed at school? ______________

Asthma triggers: ______________ (List home meds on page 2).

Diabetes ◯ Yes ◯ No Type 1 ____ Type 2 ____ Oral meds or insulin? ______________

Blood sugar checks needed? ◯ Yes ◯ No (Please provide the physician's written plan of care).

Epilepsy/Seizures ◯ Yes ◯ No Describe seizures: ______________

Medications for seizures: ______________

Heart Condition ◯ Yes ◯ No ______________

Bone/Joint Problems ◯ Yes ◯ No ______________

ADD/ADHD ◯ 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: ____________ Last time dose taken: ____________

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Reason: ____________ Last time dose taken: ____________

Name of daily medication: ____________ Dosage: ____________ Times taken: ____________
Reason: ____________ Last time dose taken: ____________

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: ____________
(Example: Urinary catheterization, tube feedings, injections, POC testing)

Special procedures required: ____________

Other health information or concerns: ____________

IEP? ◯ Yes ◯ No Diagnosis: ____________ 504? ◯ Yes ◯ No Diagnosis: ____________

Procedure for Administration of Medications

1. All medications that are given routinely must be in original container with current date. Labeled with: name, route, dosage/amount, time, name of medication must be clear, easily seen and legible. Amount verified, and permission obtained. Dosages cannot exceed manufacturer's recommendation.
2. OTC medications must be furnished by parent/guardian if given routinely. Must be brought to the health office in original container. Amount verified, and permission obtained. Dosages cannot exceed manufacturer's recommendation.
3. Medications from home will not be shared with other students. They can only be given to the students whose name appears on the bottle.
4. Nurse will use reasonable and prudent judgment to determine whether or not to administer a particular medication. Please remember to inform nurse what time last home dosage was given.

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:** ____________

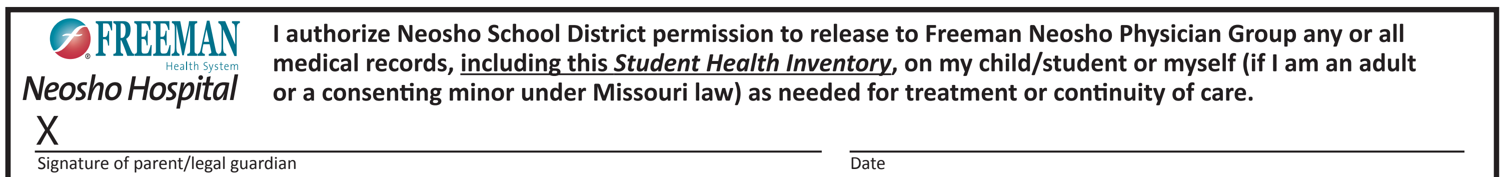
By signing this, I give Neosho School District school nurse permission:
To provide first aid treatment to my child while at school. Not limited to, but included are: antiseptic solution for cleaning wounds, triple antibiotic ointment to wounds, use of anti-itch creams and sprays for conditions such as insect bites, rashes, etc. latex-free band-aids, tapes and dressings, splints (wooden or metal) to movable joints, if necessary. Ice packs, warm compresses, cool compresses, eye wash solution and the use of peppermint lozenges, and antacids for minor stomach discomfort/nausea. Cough drops after assessment.

I give consent for health information related to my child to be released to school personnel on a medical need-to-know basis.

I give permission for the school nurse to obtain immunization records on my child from clinics, health department and health care providers.

State health regulations dictate that students **cannot attend school** unless they are properly immunized and can provide satisfactory evidence of the immunizations or unless they are exempted. For school attendance, children should be immunized against diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, hepatitis B and varicella. Also 7th through 12th grades must provide documentation of immunization for meningitis. Boosters may be required for several of these immunizations. All children are required to provide documentation of the month, day, and year of vaccine administration.

X ____________ ____________
Signature of parent/legal guardian Date



I authorize Neosho School District permission to release to Freeman Neosho Physician Group any or all medical records, <u>including this *Student Health Inventory*</u>, 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

Some additional forms are required to be filled out for those students with special needs, allergies, asthma, diabetes, seizures. They will be sent home with your child. Please return as soon as possible, so we can provide good care for your child at school.