

# Student Health Inventory

McDonald County R-1 Schools 2014/2015 School Year

Grade: \_\_\_\_\_

Date: \_\_\_\_\_

Student \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ Birth date \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Street Address or P.O. Box \_\_\_\_\_

City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

Parents/Guardians \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phones \_\_\_\_\_ / \_\_\_\_\_

Email address \_\_\_\_\_

Parent's Employment (Father) \_\_\_\_\_ Phone \_\_\_\_\_

(Mother) \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contacts: (1<sup>st</sup> Choice) Name \_\_\_\_\_ Phone \_\_\_\_\_

(2<sup>nd</sup> Choice) Name \_\_\_\_\_ Phone \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_ Exam in the last year? Yes \_\_\_\_\_ No \_\_\_\_\_

Dentist's/Orthodontist's Name \_\_\_\_\_ Phone \_\_\_\_\_ Exam in the last year? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your student have private insurance? Yes \_\_\_\_\_ No \_\_\_\_\_ Group Name/Number \_\_\_\_\_

Medicaid? Yes \_\_\_\_\_ No \_\_\_\_\_ ID# \_\_\_\_\_

Where should your child be taken in case of emergency? \_\_\_\_\_

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

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 \_\_\_\_\_

Takes daily medication at home? Yes \_\_\_\_\_ No \_\_\_\_\_ At school? Yes \_\_\_\_\_ No \_\_\_\_\_ Emergency only? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of medication and reason for taking \_\_\_\_\_

List serious illnesses, injuries, surgeries \_\_\_\_\_

Any condition that prevents PE participation? (Restriction from medical doctor required) \_\_\_\_\_

I understand that health information will be shared, in confidence, with school staff as determined to be necessary by the school nurse.

I understand that it is my responsibility as a parent/guardian to provide transportation for my sick child.

I, the undersigned, do hereby authorize officials of McDonald County R-1 Schools to administer emergency medical care/first aid to my child when needed.

I, the undersigned, do hereby authorize officials of McDonald County R-1 Schools to contact directly the persons named, and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of my child.

In the event physicians, other persons named on this form or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Signature Parent/Guardian \_\_\_\_\_

Date: \_\_\_\_\_