Student Health Registration Form / *RETURN TO SCHOOL NURSE*

This questionnaire is designed to aid the school nurse in anticipating any health concerns that might affect your child's safety or learning.

Student Name _____ Grade ____ Sex ____ Date of Birth _____
LAST FIRST MI

MEDICAL

Does your child have a doctor or nurse practitioner? Yes ___ No ___
Name of child's doctor or nurse practitioner _____ Phone # _____
In the past 12 months, did you have problems obtaining medical care for your child? Yes ___ No ___

DENTAL

Does your child have a dentist? Yes ___ No ___
Name of child's dentist _____ Phone # _____
Did your child receive a dental exam in the last 12 months? Yes ___ No ___
Describe the condition of your child's teeth? Good ___ Fair ___ Poor ___
In the past 12 months, did you have problems obtaining dental care for your child? Yes ___ No ___

INSURANCE

Does your child have medical insurance coverage? Yes ___ No ___ Name of Provider _____
Does your child have dental insurance coverage? Yes ___ No ___ Name of Provider
Does Medicaid (MO HealthNet) insure your child? Yes ___ No ___

MEDICAL HISTORY

Have you ever been told by a physician or health care professional that your child has:

___Asthma ___Seizure disorder ___Bleeding disorder ___ADD/ADHD
___Diabetes ___Bone/muscle disease ___Skin condition ___Learning disability
___Heart condition ___Mental health condition (i.e. depression, anxiety, eating disorder) ___Other_____

Does your child experience any of the following?

___Nose bleeds ___Frequent ear aches ___Overweight for age ___Physical disability
___Poor appetite ___Frequent stomachaches ___Frequent headaches ___Fainting spells
___Tires easily ___Emotional concerns ___Underweight for age ___Other _____

Do any of the condition(s) limit/effect your child at school? _____

LIFE-THREATENING CONDITIONS

Does your child have a life-threatening health condition? Yes* ___ No ___ Describe: _____

ALLERGIES

___Plants ___Animals ___Food ___Molds ___Drugs ___Bees ___ Other _____
Please describe the allergic reaction and the treatment for each checked allergy _____
_____

Do you plan for your child to receive school prepared meals? Yes ___ No ___
Will your child require food substitutions? Yes** ___ No ___

****The Medical Statement for Student Requiring Special Meals must be completed to allow food substitutions.**

MEDICATION

Does your child take any medication? Yes ___ No ___ If yes, name of medication(s) _____
Purpose _____ Will medication be needed at school? Yes* ___ No ___

If the answer to any of these questions is yes, please call to schedule a time to meet with the school nurse!

HEARING/VISION

Do you have concerns about your child's hearing? Yes ___ No ___ Does your child wear hearing aids? Yes ___ No ___
Do you have concerns about your child's vision? Yes ___ No ___ Does your child wear glasses or contacts? Yes ___ No ___

SPEECH/LANGUAGE

Do you have concerns about your child's speech and/or language? Yes ___ No ___
Do others have difficulty understanding your child? Yes ___ No ___ If yes, please explain _____
_____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I understand the information given above will be shared with appropriate school staff to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand I will assume full responsibility for payment of any transport or emergency medical services rendered.

Parent/Guardian Signature _____ Date _____

Adapted from OSPI Anaphylaxis Guidelines

SAINT LOUIS PUBLIC SCHOOLS

Student Health Assessment Form / *RETURN TO SCHOOL NURSE*

This questionnaire is designed to aid the school nurse in anticipating any health concerns that might affect your child's safety or learning.

Student Name _____ Grade ____ Sex ____ Date of Birth _____
LAST FIRST MI

INSURANCE

Does your child have medical/health insurance coverage? Yes ___ No ___
If no, does Medicaid (MO HealthNet) insure your child? Yes ___ No ___

MEDICATION

Does your child take any medication that needs to be administered during school hours? **Yes*** ___ No ___

Does your child have any food allergies? **Yes*** ___ No ___

(Optional) Please provide any other health related information that you believe the District should know to better serve your child:

_____

_____

_____

*Please complete the reverse side (OHS09B) if you answer "Yes" and return to the school nurse.

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I understand the information given above will be shared with appropriate school staff to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand I will assume full responsibility for payment of any transport or emergency medical services rendered.

Parent/Guardian Signature _____ **Date** _____