Warren County R-III School District

Health Information Sheet (*This form will be updated yearly)

FOR OFFICE USE ONLY: ☐ DBE ☐ WRE ☐ RBE ☐ BHMS ☐ WHS

Date:____/____/____

Student's Full name: _____ **Grade:** _____

First Middle Last

Gender: M ☐ F ☐ **Date of Birth**____/____/____

Medical:

Physician: _____ Phone #: _____

Date of student's last physical exam: ____/____/____

List previous accidents, surgeries, etc. with dates: _____

_____

Insurance Information:

Does the student have medical insurance coverage? ☐ Yes ☐ No ☐ Don't Know

Name of Provider: _____

Does Medicaid (Mo HealthNet) insure the student? ☐ Yes ☐ No ☐ Don't Know

Student's Birth History: ☐ Normal ☐ Premature

Complications/ Congenital defects:_____

Please check all that apply, include approximate date:

Student has had:

- ☐ _____ Chicken Pox
- ☐ _____ German Measles
- ☐ _____ Hepatitis
- ☐ _____ Measles
- ☐ _____ Poliomyelitis
- ☐ _____ Rheumatic Fever
- ☐ _____ Scarlet Fever
- ☐ _____ Whooping Cough
- ☐ _____ Meningitis

Student often has:

- ☐ Fever (over 105 for _____days)
- ☐ Headache
- ☐ Colds
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Tires easily
- ☐ Skin problems
- ☐ Joint Pain
- ☐ Fainting Spells
- ☐ Sleep Walking
- ☐ Bathroom Accidents
- ☐ Stomach Aches
- ☐ Nose Bleeds
- ☐ Poor appetite
- ☐ Other _____

Student has now (or) has had:

- ☐ _____ Artificial Limb
- ☐ _____ Bone/Muscle Disease
- ☐ _____ Cystic Fibrosis
- ☐ _____ Depression
- ☐ _____ Heart Disease/Condition
- ☐ _____ Muscular Dystrophy
- ☐ _____ Physical Disability
- ☐ _____ ADD/ADHD ☐ Takes medication

  Name of Medication(s):_____

  _____
- ☐ _____ Asthma ☐ Takes medication

  Name of Medication(s):_____

  _____
- ☐ _____ Bleeding disorder
- ☐ _____ Cancer
- ☐ _____ Deformity
- ☐ _____ Emotional/ Stress-related problems
- ☐ _____ Multiple Sclerosis
- ☐ _____ Overweight or Underweight for age

Student has now (or) has had: (continued)

☐ _____ Seizure disorder ☐ Takes medication

Name of Medication(s):_____

_____

☐ _____ Diabetes ☐ Diet Controlled ☐ Takes Medication

Name of Medication(s):_____

_____

Medication:

Does your student take any medication(s)? ☐ Yes ☐ No

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**

Life-Threatening Conditions:

Does the student 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 student to receive school prepared meals? ☐ Yes ☐ No

Will your student require food substitutions? ☐ Yes** ☐ No

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

Hearing/Vision Problems:

Does your student wear hearing aids? ☐ Yes ☐ No

Does your student wear glasses or contacts? ☐ Yes ☐ No

Physical problem(s) that may limit physical activity: _____

_____

****A COPY OF IMMUNIZATION RECORDS IS REQUIRED AT TIME OF SCHOOL REGISTRATION****

PLEASE KEEP THE SCHOOL NURSE UPDATED AS YOUR STUDENT RECEIVES REQUIRED IMMUNIZATIONS

PLEASE KEEP THE SCHOOL NURSE UPDATED IF YOUR CHILD'S MEDICATION CHANGES

I understand the information given above will be shared with appropriate school staff 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:** __/__/__

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