Moniteau R-V School District

LATHAM BRAVES

Student Health Information

*This form must be completed each year

STUDENT INFORMATION

Your child's learning depends upon good health. To assist in providing health services at school, please complete the following.

Last _____ First _____ Middle _____

Grade _____ Gender: M F Date of Birth (mm/dd/yy): _____

Teacher (leave blank if NEW Student Enrollment) _____

Parent/Guardian _____ Home Phone _____

Father's Employer _____ Mother's Employer _____

Father's Work # _____ Mother's Work # _____

Father's Cell # _____ Mother's Cell # _____

EMERGENCY CONTACT INFORMATION ---- Other Than Parents

Name _____ Relationship to Student _____

Phone # _____

Name _____ Relationship to Student _____

Phone # _____

MEDICAL INFORMATION

Doctor's Name _____ Phone Number _____

Dentist's Name _____ Phone Number _____

Hospital Preference: Capital Region Medical Center St. Mary's Hospital

Does your child have…

Allergies Yes No Please list: _____

(foods, drugs, latex, etc.)

Has the allergy required emergency action in the past? Yes No

Comments: _____

Bee Sting Allergy Yes No Describe reaction: _____
Any difficulty breathing? Yes No Need Emergency medication? Yes No

Asthma Yes No Triggered by: _____
Treatment: _____
Diagnosed by doctor (name): _____
Date Diagnosed: _____

Diabetes Yes No Takes Insulin: _____
Date diagnosed: _____

Epilepsy/Seizures Yes No Describe seizure: _____
Date of last seizure: _____
Medication: _____

Heart Condition Yes No Describe condition: _____
Physical restriction: _____

Bone or Joint Problem Yes No Describe: _____
Physical restrictions: _____

Emotional/Behavior Yes No Diagnosis or description: _____
Treatment (doctor, counselor, etc.) _____

Daily Medications:

At Home? Yes No Name of Medication: _____
Dosage Time: _____

At School? Yes No Name of Medication: _____
Dosage Time: _____

Emergency Only? Yes No Name of the Medication: _____
Dosage Time: _____

Eyes *(circle all that apply)*

glasses reading distance contacts crossed lazy eye headaches difficulty seeing

Ears *(circle all that apply)*

frequent infections tubes hearing difficulty history of hearing problems in the family
talks loudly hearing aid --- left right wears hearing aid at school - yes no

Other Concerns

Nosebleeds bowel diapers catheterization bedwetting headaches lungs skin
ADD / ADHD neurological blood disorder blood pressure menstruation

Childhood diseases, serious illness, and injuries: _____

Surgeries: _____

Low Birth Weight Yes No

Any condition(s) that prevent PE participation: _____

DIETARY NEEDS

Special Diet: _____ Doctor who prescribed the diet _____

Will your child require food substitution? Yes No

A specific form signed by a licensed physician is required before allowing meal or drink substitution at school.

Requires special health care (explain): _____

Other health information or concerns: _____

Special procedures required: _____

If the school Nurse is expected to administer medication (Prescription or Non-prescription) to your child, a **MEDICATION FORM** must be completed and on file. When the medication is changed, a new form must be submitted. Medication **MUST BE** in the original bottle and ***brought in by the Parent.***

Please circle below ALL medications the Moniteau R-V School District has your permission to give your student.

Acetaminophen (Tylenol) Ibuprofen Tums Cough Drops

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/Legal Guardian Signature **Date**