

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:

Student often has:

- Chicken Pox, German Measles, Hepatitis, Measles, Poliomyelitis, Rheumatic Fever, Scarlet Fever, Whooping Cough, Meningitis, 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, Bleeding disorder, Cancer, Deformity, Emotional/ Stress-related problems, Multiple Sclerosis, Overweight or Underweight for age, Takes medication, Name of Medication(s): \_\_\_\_\_, Asthma, Takes medication, Name of Medication(s): \_\_\_\_\_

**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:** \_\_\_\_/\_\_\_\_/\_\_\_\_