

DREXEL R-IV SCHOOL

Teacher _____

HEALTH INFORMATION UPDATE 2016-2017 Grade _____

Name _____ Birthdate _____ Age _____
Last First Middle

Goes By _____ Male Female

Address _____ Phone Number _____

Father's Name _____ Daytime Phone _____ Cell Phone _____

Mother's Name _____ Daytime Phone _____ Cell Phone _____

IN CASE OF AN EMERGENCY, WE MUST HAVE TWO LOCAL PERSONS OTHER THAN PARENTS WHO CAN BE CONTACTED. GIVE NAME, DAYTIME PHONE AND CELL PHONE NUMBERS.

1. Name _____ Daytime Phone _____ Cell Phone _____

2. Name _____ Daytime Phone _____ Cell Phone _____

Doctor's Name _____ Phone Number _____

Has your child had a well-child or physical exam within the past 12 months? Yes No Date _____

Dentist's Name _____ Phone Number _____

Date of last dental exam _____ Dental sealants? Yes No

Is your child under an orthodontist's care? Braces Retainer Dentures

Does student have: Private health insurance? Yes Medicaid/MC+ Yes No insurance of any kind

If emergency treatment is required, and the parents or emergency contacts cannot be reached immediately, may the school authorities take your child to the hospital for treatment? Yes No

(If the school cannot reach you or your contacts and your child needs to be transported by ambulance, the school district will not be responsible for payment of transportation.)

PLEASE CHECK THE FOLLOWING HEALTH CONCERNS WHICH PERTAIN TO YOUR CHILD

Allergies: Food Drugs Insect stings Bee/Wasp Stings Pollen Environmental None

Specify Allergy _____

Describe reaction _____

Required medication/allergy shot _____

Does allergy require emergency action? _____

Does this allergy cause a life threatening reaction? Yes No

Asthma Yes No Mild Moderate Severe Requires treatment while at school? Yes No

Triggered by _____

Treatment/Medication _____

Activity limitations _____

Diabetes Yes No Self maintenance Yes No Glucose monitoring times _____

Takes insulin Required medication/dosage time _____

Hypoglycemia (low blood sugar) Yes No

Special Diet _____

Eyes Does he/she wear glasses? Yes No (distance reading always) Contacts

Ears Hearing Difficulty – Yes No: explain _____

hearing aide Rt Lt Wears at school? Yes No Frequent Infections Tubes inserted removed

Convulsive Disorders/Epilepsy/Seizures Yes No Describe seizure Grand Mal Petit Mal Other
Date of last seizure _____ Medication _____
Is the student currently under a doctor's care for seizures? Yes No
Doctor's name _____ Phone _____
Activity restrictions? _____

Heart Condition Yes No
Describe Specifically _____
Any physical restrictions _____
Medications _____

Bone or joint problems Yes No
Handicap Yes No Explain _____

Head Injury Yes No Explain _____

Emotional Problems Yes No Explain _____

Kidney Disease/Chronic urinary tract infections Yes No Explain: _____

Other Concerns: ADD/ADHD bladder requires catheterization bowel requires diapering blood disorder
 blood pressure eating headaches menstruation neurological nosebleeds phobias(fears)
 sleeping skin other explain _____

ARE THERE ANY OTHER HEALTH PROBLEMS OR CONCERNS WHICH MIGHT AFFECT YOUR CHILD'S SCHOOL WORK OR ACTIVITIES? Explain: _____

Student takes routine daily medication at home? Yes No At school? Yes No

Name of medication and reason for taking _____

Surgeries in past 12 months _____

Serious injuries in past 12 months _____

Serious illness in past 12 months _____

Health Condition diagnosed in past 12 months? _____

Has your child had any of the following diseases? **If so, list month and year.**

Chicken Pox _____ Strep Throat _____ Mononucleosis _____ Hepatitis _____ Whooping Cough _____

Has your child had a lead test? Yes No **If yes, list M/D/Y** _____

If your child has had any immunizations during the past 12 months, please make sure the school health office has an updated photocopy on file.

I give permission for the school nurse to discuss pertinent health information regarding my child, as needed, with designated Drexel R-IV staff members. I am aware that this information will be released only for the purpose of providing continuity of care to my child and understand that the designated staff members have signed a School Health Confidentiality Statement to guard against improper release of student health information.

Signature (Parent/Guardian)

Date

Thank you for your prompt attention and cooperation in this matter. The above information will help us to better care for your child during the school day. Please feel free to contact the school nurse at 816-657-4715 with any changes, questions or concerns.