MONITEAU SCHOOL DISTRICT
CONFIDENTIAL EMERGENCY HEALTH INFORMATION FORM

Student's Name:_____ **Age:** _____ **D.O.B.:**_____ **Grade:** _____
Address:_____ **Home Phone:** (_____)_____
_____ **Email Address:** _____

Student Lives With:

_____

Please list name(s) and grade(s) of sibling(s) who attend Moniteau School District:

1) _____Gr._____ **2)** _____Gr._____ **3)** _____Gr._____

Mother/Guardian's Name: _____ **Cell Phone:** (_____)_____

Place of Employment: _____ **Work Phone:** (_____)_____

Father/Guardian's Name: _____ **Cell Phone:** (_____)_____

Place of Employment: _____ **Work Phone:** (_____)_____

***In case of an illness and the school nurse is unable to reach the contacts listed above, please call the following contacts who will assume responsibility/transportation for my child:**

Name:_____**Relationship:**_____**Phone #:** (_____)_____

Name:_____**Relationship:**_____**Phone #:** (_____)_____

****If there is someone your child <u>should not</u> be dismissed to, note here**_____

Does your child have health insurance? ____No ____ Yes

Medical Insurance Carrier: _____ **Policy Number:** _____

I understand that in a life threatening situation, the school district is required by law to transport my child to the nearest hospital.

Physician's Name: _____ **Phone #** (_____)_____

Dentist's Name: _____ **Phone #** (_____)_____

I give the school nurse permission to give my child the following medication, if needed, during school hours. (Please check) If these are ***not*** checked and signed by parent/guardian, the medications ***will not*** be administered to your child.

_____Tylenol _____Ibuprofen _____Benadryl _____TUMS _____Eye Drops _____ Pepto-Bismol

_____ _____

Parent/Guardian's Signature **Date**

***** Please turn over and complete the reverse side of this form. *****

MONITEAU SCHOOL DISTRICT
HEALTH HISTORY FOR SCHOOL NURSE

TO HELP ME KNOW YOUR CHILD BETTER AND PROVIDE NECESSARY CARE, PLEASE COMPLETE THE FOLLOWING:

PLEASE CHECK THE FOLLOWING CONDITIONS THAT PERTAIN TO YOUR CHILD:

_____Asthma
_____Inhaler: _____
(Name of inhaler)

_____ ADD / ADHD
_____ Medication: _____

_____Allergy:
_____Food:_____
_____Medication:_____
_____Insect: _____
EPI-PEN Required: _____yes _____ *no*

_____ *Celiac Disease / IBS (circle)*

_____ Convulsions / Epilepsy / Seizures (circle)

_____ Diabetes

_____ Head injury/concussion
Date: _____

_____ Hearing Defect
_____ Hearing aids

_____ Heart Condition
_____

_____ Hospitalization
Date(s) : _____
Reason: _____
_____

_____ Migraines
Rx Medication:_____

_____ Orthopedic Problems
_____

_____ Psychological Problems (depression, anxiety)
_____

_____ Vision Deficit (Distance / Reading)
_____ Glasses
_____ Contacts

_____ Other
_____
_____

1. Does your child have a condition that requires regular medication? _____Yes _____No
   If yes, please list <u>all</u> daily medication(s) and time taken: _____
   _____
2. Is your child presently under the care of a physician?_____
   If yes, please explain._____
3. Are there any restrictions of activities?_____
   _____

* If your child has a condition or health issue that is not mentioned on this form, please attach a separate piece of paper to this form explaining details. This side of the form is ***<u>confidential</u>*** and will remain in the Nurse's Office.

*** Please turn over and complete the reverse side of this form. ***