Moberly School District
Student Health Registration Form

School Year: 2019-2020

Form must be completed and signed at the bottom ❑ confidential copy

M F

Last Name First Name Middle Gender Date of Birth Grade Bldg

Medical provider/Clinic: _____ Well Child Exam in the last ❑ 1 year ❑ 2 year

Dentist name: _____ Dental Exam in last ❑ 1 year ❑ 2 year

Hospital Preference: _____ Health Insurance: ❑ Medicaid ❑ MoHealthNet

❑ MY CHILD HAS *NO* HEALTH CONCERNS (SIGN FORM AT BOTTOM) ❑ None ❑ Employer/private

❑ MY CHILD HAS THE FOLLOWING HEALTH CONCERN(S):

❑ EYES: ❑ glasses (❑ reading / ❑ distance) ❑contacts
❑ lazy eye ❑ difficulty seeing____ ❑ previous surgery _____❑other: (explain):

❑ EARS: ❑ frequent infections ❑ tubes: ❑ right ❑ left ❑ Date inserted:_____ hearing difficulty (explain)
❑_____hearing aid: ❑ right ❑ left ❑ wear at school ❑ other (explain): _____

❑ _____ALLERGIES*: (drugs, foods, insects, pollens) Please list: _____

❑Allergy is life threatening Treatment: ▫epinephrine ▫antihistamine ▫other: _____

❑ ASTHMA*: Has symptoms 2 or more times a week *or* month *o*r year Prescribed: ▫albuterol ▫corticosteroid ▫ epinephrine

❑ _____ SEIZURE DISORDER*: Date of last seizure:_____ ▫prescribed emergency medication

❑ _____DIABETES*: ❑ Insulin dependent ❑ Non-insulin dependent Medications:_____Taken at: ❑Home ❑School

***If your child has these conditions, contact the school nurse to discuss care of your child at school**

❑ _____ATTENTION DEFICIT DISORDER: (❑ADD/ ❑ADHD) Medications:_____

❑ _____MENTAL HEALTH: ❑ depression ❑anxiety ❑ bipolar ❑ other:_____
Mental Health care provider: _____

❑ _____ MEDICATIONS:Reason for taking:
Taken at: ❑ Home ❑ School

Other Health Concerns: ❑heart condition ❑bleeding disorder❑nosebleeds ❑eating ❑sleeping ❑bowel ❑kidney ❑dental ❑skin ❑lungs ❑orthopedic ❑genetic disorder ❑neurologic ❑headaches ❑ concussion/ TBI ❑hospitalization ❑other SPECIFY:

❑ Child requires nursing care at school (specify):

***AUTHORIZATION FOR EMER*GENCY MEDICAL TREATMENT**

In case of a critical

❑_____ RN
Review: (date:_____) ❑ SIS (date:_____) CONTACT: _____ date:
NOTIFICATIONS: ❑ teacher ❑bus driver ❑ office CARE PLAN ❑ asthma ❑ allergies ❑ diabetes ❑ seizures

emergency, emergency medical services (911) and the parent/guardian will be contacted. If the parent/guardian cannot be reached, the emergency contacts provided will be called. The cost of medical care and ambulance services is the responsibility of the parent or guardian.

The above health information is accurate. I understand the school nurse may share health information with school staff and the child's medical **care provider in order to provide for my chi**ld's health and safety.

Parent/Guardian Signature _____ Date