

Moberly School District

Student Health Registration Form

School Year: 2018-2019

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 or 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 EMERGENCY MEDICAL TREATMENT

In case of a critical 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 child's health and safety.

Parent/Guardian Signature _____ Date _____

Revised 3/2018

RN Review: (date: _____) SIS (date: _____) CONTACT: _____ date: _____
NOTIFICATIONS: teacher bus driver office CARE PLAN asthma allergies diabetes seizures
Copy: Counselor Resource Coordinator IHP