Moberly School District

Student Health Registration Form School Year:

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

Last Name	First Name	Middle	M F 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: _____

☐ **SICKLE-CELL DISEASE:** Restrictions:_____

☐ **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 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 3/2016

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

Moberly School District

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If your child requires medication during school hours, please sign and complete the form below.

Medication Form

Date: _____

Name of Student: _____ Date of Birth: _____ Grade: _____

Medication name: _____Dosage: _____

Time(s) to be given: _____For treatment of:_____

Prescription medication: _____Prescribing Physician:_____Pharmacy_____

RX#: _____ Expiration date: _____

►Parent/guardian signature*: _____

Medication Form

Date: _____

Name of Student: _____ Date of Birth: _____ Grade: _____

Medication name: _____Dosage: _____

Time(s) to be given: _____For treatment of:_____ _____

Prescription medication: _____Prescribing Physician:_____Pharmacy_____

RX#: _____ Expiration date: _____

►Parent/guardian signature*: _____

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