Moberly School District

Student Health Registration Form School Year:

□ EARS: □ frequent infections □ tubes: □ right □ left □ Date inserted: hearing difficulty (explain) hearing aid: □ right □ left □ wear at school □ other (explain):		□ confidenti	☐ confidential copy				
Medical provider/Clinic:				M F			
Dental Exam in last	Last Name	First Name	Middle	Gender	Date of E	Birth Grade	Bldg
Hospital Preference: Health Insurance: Medicaid MohealthNet MY CHILD HAS NO HEALTH CONCERNS (sien FORM AT BOTTOM) None Employer/private MY CHILD HAS THE FOLLOWING HEALTH CONCERNS:	Medical provider/Clin	ic:	Well	Child Exam i	in the last	□ 1 year □ 2 y	year
MY CHILD HAS NO HEALTH CONCERNS (SIGN FORM AT BOTTOM)							
MY CHILD HAS THE FOLLOWING HEALTH CONCERN(5): EYES: glasses (reading / distance) contacts lazy eye difficulty seeing previous surgery other: (explain): lazy eye difficulty seeing previous surgery other: (explain): lazy eye difficulty seeing previous surgery other: (explain): lazy eye difficulty seeing chearing aid: right left wear at school other (explain): lazy eye difficulty (explain) lazy eye difficulty (explain) lazy eye lazy eye difficulty (explain) lazy eye la	Hospital Preference: _		Healt	h Insurance	: 🗆 Medica	id 🗆 MoHealthNe	t
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 diff: diright left wear at school other (explain): ALLERGIES*; (drugs, foods, insects, pollens) Please list: Allergy is life threatening Treatment: Prescribed Pr	☐ MY CHILD HAS <u>NC</u>	D HEALTH CONCERNS (SIGN I	FORM AT BOTTOM)		□ None	☐ Employer/priva	ite
lazy eye difficulty seeing previous surgery other: (explain): EARS: frequent infections ubes: right left Date inserted: hearing difficulty (explain)	☐ MY CHILD HAS TH	IE FOLLOWING HEALTH CO	ONCERN(S):				
Allergy is life threatening	□ lazy eye □ EARS: □ frequent in	☐ difficulty seeing ☐ fections ☐ tubes: ☐ right ☐	previous surgery left □ Date inserted	: hea	ring difficult	ty (explain)	
□ Allergy is life threatening Treatment: □epinephrine □antihistamine □other: □allowers □ 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 □ 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: □ □ MEDICATIONS: □ Reason for taking: □ □ 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 □ 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. <	☐ hearing aid: ————	: □ right □ left □ wear at scho	ool \square other (explain):				
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	Parent/Guardian Signa	ature			D	ate	

 \square IHP

Copy: \square Counselor \square Resource Coordinator

Moberly School District

Student Health Registration Form School Year:

Form must be completed and signed at the bottom

☐ confidential copy

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#:Exp	piration date:		
► Parent/guardian signat	ure*:		
Medication Form			
Date:			
		Date of Birth:	Grade:
			 Dosage:
			Pharmacy
RX#:Exp			
	 ure*:		
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