

Moberly School District

Student Health Registration Form School Year: _____

Form must be completed and signed at the bottom

confidential copy

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Last Name	First Name	Middle	Gender	Date of Birth	Grade	Bldg
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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 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 3/2016

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

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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*: _____

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

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▶ Parent/guardian signature*: _____