# West County Elementary
# Student Health Record

Name:_________________________________ Age:____ Birth date:_____________
*last* *first* *middle*
male___ female___ Grade:____ Teacher:__________________
Home phone #______________________
Mother___________________ Cell phone:______________Work phone:_____________
Father____________________Cell phone:______________ Work phone:_____________

## Emergency Contacts

**Please list 2 people to be contacted in case your child gets sick or injured and you cannot be reached to pick up your child.

1. Name:____________________ Relationship:_______________Phone #_______________
2. Name:____________________ Relationship:_______________Phone #_______________

## Insurance

Private___ MO HealthNet___ (#____________________) None___

## Medical Information

Doctor______________________ Phone #_________________
Dentist______________________ Phone #_________________
Preferred hospital______________________________________

Please list any medications your child will be taking at school:

____________________________________________________________________________
**Please, do NOT send any medications to school with your child (prescription OR over the counter) Any meds must be brought to school by a responsible adult.**

Home medications:________________________________________________________________

**You must get a form from the nurse for your physician to fill out before ANY prescription medication can be given at school.

## Authorization for Emergency Treatment

I do hereby authorize the administrative or medical representative to conduct whatever emergency medical treatment his/her judgement may deem advisable in the event that my son/daughter should suffer any accident or sickness while a student of the West Co. R-IV School District. I will accept any doctor available in a life threatening situation. I understand that the child will be transported to the nearest medical facility in a life threatening emergency as determined by school officials and I will be contacted immediately.
*I authorize this representative to call an ambulance if necessary and accept responsibility for my child's medical expenses.
*I give my permission for the West Co. R-IV School District to release any medical and immunization information to other school districts is my child is transferred.

Parent/Guardian Signature________________________ Date______________

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| | *Health History* |
|---|---|
| ASTHMA | Type:<br>Medication: |
| BLOOD DISEASE<br>Anemia, Hemophilia, etc. | Type:<br>Special needs: |
| CARDIAC | Type:<br>Special needs: |
| DIABETES | Type:<br>Medication:<br>Special needs: |
| SEVERE FOOD ALLERGY | Food:<br>Reaction: |
| DIGESTIVE DISORDER<br>Food intolerance, etc. | Type:<br>Special needs: |
| HEARING IMPAIRMENT | Describe:<br>Special needs: |
| INSECT STING ALLERGY | Type:<br>Reaction: |
| MALIGNANCY | Type:<br>Special needs: |
| NEUROLOGICAL PROBLEM<br>Hydrocephalus, Cerebral Palsy | Type:<br>Special needs: |
| ORTHOPEDIC PROBLEM<br>Arthritis, Muscular Distrophy,etc | Type:<br>Special needs: |
| RESPIRATORY PROBLEM<br>Cystic Fibrosis, etc. | Type:<br>Special needs: |
| SEIZURE DISORDER<br>Epilepsy, etc. | Type:<br>Special needs: |
| URINARY/KIDNEY DISORDER<br>Nephritis, etc. | Type:<br>Special needs: |
| BEHAVIOR DISORDER | Type:<br>Medication:<br>Special needs: |
| DRUG ALLERGY | Medication:<br>Reaction: |
| SERIOUS ILLNESSES/INJURIES | Describe:<br>Special needs: |
| SKIN PROBLEMS<br>Eczema, etc | Describe:<br>Special needs: |
| VISION PROBLEMS | Glasses or Contact lenses?: |
| OTHER HEALTH PROBLEMS | |
| | |

[ ] *None of the above*

[ ] The health condition that I have described above is of sufficient concern that I would like to consult with the school nurse. I therefore agree to contact the school nurse at (573)562-7558.

Over-the-Counter Medications
Parent Authorization

Using appropriate nursing knowledge, judgment, and assessment skills, the school nurse may determine that your child could possibly benefit from an *over-the-counter* medication. These medications would be given only to those students with minor complaints who are otherwise in good health.

If your child seems to need any of these medications more often than occasionally, the nurse may request that you have a physician's evaluation and authorization to continue administering the medication. A manufacturer labeled container of the medication to be used only by your child should be sent in to school from home.

Each year it is necessary to have your written approval on record at the school. Please return this form even if you do not want your child receiving medication at school, just check the appropriate box**. Verbal parental permission will still be obtained by a phone call prior to giving medication unless checked otherwise.**

☐ Yes, my child may have the following medications.

-**Children's Tylenol** as directed by mouth for headache, fever or minor pain
-**Children's Motrin** as directed by mouth for headache, fever or minor pain
-**Antacid** (Tums,Mylanta) for upset stomach.
-**Cough drops** for cough or sore throat
-**Hydrocortisone 0.5% ointment**, **Calamine lotion**, **Antibiotic cream** for minor skin conditions
-**Children's Benadryl** as directed by mouth for sneezing, runny nose, itchy eyes or throat
-**Orajel** for toothache

☐ *Do not call before my child gets medication, just send a note home.*

☐ **I do not want my child to receive any medication while at school.**

*****************************************************************************

Child's Name :____________________________________________________

[ ] My child has no known medication allergies.

[ ] My child is allergic to: ____________________________________

Date________________ Signature ___________________________________
Parent/guardian