Park Hill School District

Confidential Student Health Form

Student Information			
Student Name (Last, First):	Gender: ☐ Male ☐ Female	Date of Birth:	Grade:

- An official copy of student's immunization record, showing student is up to date with Missouri Immunization requirements must be on file for enrollment.
- Students in progress for immunizations must receive immunizations as soon as they are due to remain in school.
- Religious and Medical exemptions are allowed with proper documentation on file.

Health Information	In the past 12 months, has student:
Insurance: ☐ Private ☐ MO HealthNet ☐ None	
Would you like the Social Worker to contact you regarding programs available for various needs? (Dental, nutrition, hygiene, clothing, insurance). ☐ Yes ☐ No	Had a physical? ☐ Yes ☐ No Had a dental exam? ☐ Yes ☐ No Been to the ER/hospital?** ☐ Yes ☐ No **If so, for what: _____
Please contact your School Nurse if you want to schedule a meeting to discuss your student's medical history.	

Does your child take medications? ☐ YES ☐ NO	Will medication be taken at school? ☐ Yes ☐ No	
Reason:	If yes, please contact nurse regarding proper procedures.	
Medication:	Dose:	Time(s):
Medication:	Dose:	Time(s):
Medication:	Dose:	Time(s):

Medical History					
Have you ever been told by a physician that your student has any of the following:					
ADHD	Yes	No	Genetic Disorder	Yes	No
Allergy	Yes	No	Head Injury/Concussion: Date injured:	Yes	No
Asthma	Yes	No	Hearing Concerns	Yes	No
Bladder Concerns	Yes	No	Heart Condition	Yes	No
Bleeding/Blood Disorder	Yes	No	Mental/Emotional Concerns	Yes	No
Bone/Joint Concerns	Yes	No	Migraine/Chronic Headaches	Yes	No
Diabetes	Yes	No	Neurological/Seizure Disorder	Yes	No
Gastrointestinal Concerns	Yes	No	Vision Concerns	Yes	No
Other: specify:					
Please explain YES answers here: _____ _____ _____					

****Please note: Park Hill health rooms do not stock medication for student use.****

- If student needs medication at school, parent must provide medication in prescription-labeled bottle or original container for over-the-counter medication.
- A Medication Authorization form must be completed for each medication to be given at school.
- Medication must be given according to prescription or product label.
- Expired medication will not be administered.
- Please contact school nurse regarding any medication questions or if student needs to self-carry medication.

Please continue on next page

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If student has any of the following medical conditions, please complete the appropriate information:

Asthma (diagnosed by physician)	
Please rate severity of student's asthma (circle) MILD 1 2 3 4 5 6 7 8 9 10 SEVERE	
What triggers an asthma attack for student:	
Signs/symptoms of an asthma attack for student:	
Asthma medications:	Will student have medications at school? ☐ Yes ☐ No

- **Parent/Guardian is expected to provide needed supplies: prescription labeled rescue inhaler or nebulizer medication, with spacer, tubing and mask/mouthpiece; signed Medication Authorization Form(s).**
- **If your student will self-carry an inhaler, please contact school nurse for proper paperwork and procedure.**
- **If student has an Asthma Action Plan from a physician, please provide a copy to the school nurse.**

Allergies (diagnosed by physician)		
Food Allergies:	Medication Allergies:	Insect Allergies:
Environmental:	Other:	
Reaction: ☐ Rash/Hives ☐ Breathing difficulty ☐ Swelling of lips/tongue, throat Other:		
Is your student's allergy considered life-threatening? ☐ YES ☐ NO		
Treatment used for allergic reaction: ☐ Benadryl ☐ Epinephrine/Epi Pen		

****If student has an allergy which may be life threatening, you MUST provide non-expired injectable epinephrine with a prescription label attached and a Food Allergy Action Plan signed by student's health care provider****

- **If student will self carry epinephrine/EpiPen, please contact school nurse for paperwork and procedure.**
- **If student needs a special meal plan, please contact school nurse for paperwork and procedure.**

Diabetes	
What type of Diabetes does student have? ☐ Type 1 ☐ Type 2	Type of insulin used?
Type of therapy: ☐ Insulin pump ☐ Insulin injections ☐ Controlled by diet	
Carb ratio for food: 1 unit of insulin for _____ grams of carbs	Correction factor for hyperglycemia: 1:_____
Will your student have glucagon at school? ☐ Yes ☐ No	Does your student need help with testing? ☐ Yes ☐ No

- **Parent/Guardian is expected to provide supplies needed supplies: glucose meter, glucose strips, insulin pump (if applicable), ketone strips, glucose tabs, snacks, insulin, syringes & lancets.**
- **Parent must provide appropriate documentation from student's physician including all orders needed for student's care at school.**
- **Please contact student's school nurse to collaborate in creating an Individual Health Plan for the school year.**

Seizure Disorder	
What type of seizures does student have?:	
What triggers a seizure for student?:	
How often does student have seizures?:	How long do student's seizures usually last?:
When was student's last seizure?:	Does student know when going to have seizure?:
Seizure medications:	Will student have medication(s) at school?: ☐ Yes ☐ No

- **Parent/Guardian is expected to provide required medications (diazepam, etc.) for student's seizure disorder to the school health room, with signed Medication Authorization Form(s).**
- **If student has a seizure plan from a physician, please provide a copy to the school nurse.**

Parent/Guardian Consent:

I understand while my student's medical information is considered confidential, it is in the best interest and safety of my student for the nurse to share specific information regarding medical conditions with other school personnel.

Signature of Parent/Guardian: _____ Relationship to student: _____ Date: _____

To be updated annually