West County High School
Student Health Record

Name:_____ Age:____ Grade:_____
last first middle

male___ female___ Birthdate: _____

Home/Main phone #_____ Student's Cell #_____

Mother_____ Cell phone:_____Work phone:_____

Father_____ Cell phone:_____ Work phone:_____

Student lives with:_____

Insurance

Private___ MO HealthNet___ (#_____) None___

Medical Information

Doctor_____ Phone #_____
Dentist_____ Phone #_____

Any prescription meds required for your student through school day? No_____ Yes_____ (List below)

_____

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/taken 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 screen my child for hearing/vision/height/weight and to release any medical and immunization information to other school districts if my child is transferred.

Parent/Guardian Signature_____ Date_____

-***Continued on back***-

Student Health Record
(*continued*)

	Health History
ASTHMA	Type: Medication:
BLOOD DISEASE Anemia, Hemophilia, etc.	Type: Special needs:
CARDIAC	Type: Special needs:
DIABETES	Type: Medication: Special needs:
SEVERE FOOD ALLERGY	Food: Reaction:
DIGESTIVE DISORDER Food intolerance, etc.	Type: Special needs:
HEARING IMPAIRMENT	Describe: Special needs:
INSECT STING ALLERGY	Type: Reaction:
MALIGNANCY	Type: Special needs:
NEUROLOGICAL PROBLEM Hydrocephalus, Cerebral Palsy	Type: Special needs:
ORTHOPEDIC PROBLEM Arthritis, Muscular Distrophy,etc	Type: Special needs:
RESPIRATORY PROBLEM Cystic Fibrosis, etc.	Type: Special needs:
SEIZURE DISORDER Epilepsy, etc.	Type: Special needs:
URINARY/KIDNEY DISORDER Nephritis, etc.	Type: Special needs:
BEHAVIOR DISORDER	Type: Medication: Special needs:
DRUG ALLERGY	Medication: Reaction:
SERIOUS ILLNESSES/INJURIES	Describe: Special needs:
SKIN PROBLEMS Eczema, etc	Describe: 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)562-2217.

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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 & authorization to continue administering the medication and that you bring in the medication to be used only by your child. However, the school will provide medication for children only needing it occasionally.

Each year it is necessary to have your written approval on record at the school. If you would prefer a phone call before med is given, ***please note your request at the bottom of this form.*** Thank you!

☐ Yes, my child may have the following medications:
(mark through any not approved)

- **Tylenol** as directed by mouth for headache or minor pain
- **Ibuprofen** as directed by mouth for headache or minor pain
- **Midol Complete** *(applies only to female students)* as directed by mouth for menstrual symptoms
- **Antacid** (Tums) as directed by mouth for upset stomach/ acid indigestion
- **Cough drops** for cough or sore throat
- **Hydrocortisone ointment, Calamine lotion, Antibiotic cream, Vaseline** for minor skin conditions
- **Benadryl** as directed by mouth for rash or allergy symptoms
- **Orajel** applied topically for toothache

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Student's Name:
_____

[ ] My child has no known medication allergies.

[ ] My child is allergic to: _____

Date_____ Signature_____
Parent/guardian