

West County Middle 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 _____

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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 Dystrophy, 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)562-2216.

West County Middle School

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

Student's Name:

[] My child has no known medication allergies.

[] My child is allergic to: _____

Date _____ Signature _____

Parent/guardian