

Student Health Registration Form

Student Name _____ Grade _____ Sex _____ Date of Birth _____

This questionnaire is designed to aid school staff in anticipating any health concerns that might affect your child's safety or learning.

MEDICAL

Does your child have a doctor or nurse practitioner? Yes ___ No ___

Name of child's doctor or nurse practitioner _____ phone number _____

In the past 12 months, did you have problems obtaining medical care for your child? Yes ___ No ___

DENTAL

Does your child have a dentist? Yes ___ No ___ Name of child's dentist _____ phone number _____

Did your child receive a dental exam in the last 12 months? Yes ___ No ___ Don't know ___

Describe the condition of your child's teeth? Good ___ Fair ___ Poor ___ Don't know ___

In the past 12 months, did you have problems obtaining dental care for your child? Yes ___ No ___

INSURANCE

Does your child have medical insurance coverage? Yes ___ No ___ Don't know ___ Name of provider _____

Does your child have dental insurance coverage? Yes ___ No ___ Don't know ___ Name of provider _____

Does Medicaid (Mo HealthNet) insure him/her? Yes ___ No ___ Don't know ___

MEDICAL HISTORY

Have you ever been told by a physician or health care professional that your child has:

___ Asthma ___ Seizure disorder ___ Bleeding disorder ___ ADD/ADHD
___ Diabetes ___ Bone/muscle disease ___ Skin condition ___ Learning disability
___ Heart condition ___ Mental health condition (i.e., depression, anxiety, eating disorder) ___ Other _____

Does your child experience any of the following?

___ Nose bleeds ___ Frequent ear aches ___ Overweight for age ___ Physical disability
___ Poor appetite ___ Frequent stomach aches ___ Frequent headaches ___ Fainting spells
___ Tires easily ___ Emotional concerns ___ Underweight for age ___

Other _____ Do any of the above condition(s) limit/effect your child at school? _____

LIFE-THREATENING CONDITIONS

Does your child have a life-threatening health condition? Yes* ___ No ___ Describe: _____

ALLERGIES

Plants ___ Animals ___ Food ___ Molds ___ Drugs ___ Bees ___ Other _____

Please describe the allergic reaction and the treatment for each checked allergy _____

Do you plan for your child to receive school prepared meals? Yes ___ No ___

Will your child require food substitutions? Yes** ___ No ___

**The Medical Statement for Student Requiring Special Meals form must be completed to allow food substitutions.

MEDICATION

Does your child take any medication? Yes ___ No ___ If yes, name of medication(s): _____

Purpose _____ Will medication be needed at school? Yes* ___ No ___

***If the answer to any of these questions is yes, please call to schedule a time to meet with the school nurse.**

HEARING/VISION

Do you have concerns about your child's hearing? Yes ___ No ___ Does your child wear hearing aids? Yes ___ No ___

Do you have concerns about your child's vision? Yes ___ No ___ Does your child wear glasses or contacts? Yes ___ No ___

SPEECH/LANGUAGE

Do you have concerns about your child's speech and/or language? Yes ___ No ___

Do others have difficulty understanding your child? Yes ___ No ___ If yes, please explain _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I understand the information given above will be shared with appropriate school staff to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand I will assume full responsibility for payment of any transport or emergency medical services rendered.

Parent/Guardian Signature _____ Date _____