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 _____

Adapted from OSPI Anaphylaxis Guidelines