Lathrop RII School

Health Registration Form

2016-2017

Students Name: _____ **Grade**: _____ Sex: M/F **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_____ Phone: _____

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: _____

Has your child received a dental exam by a dentist in the last 12 months? Yes____ No____

Any Dental Concerns for your child? _____

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_____ Provider_____

Does your child have dental insurance coverage? Yes_____ No_____ Provider_____

Does your child have Medicaid (MO Health Net) coverage? Yes____ No_____

MEDICAL HISTORY:

Have you ever been told by a physician that your child has:

____Asthma*	____Seizure Disorder*	____Bleeding Disorder*	____ Heart Condition (restrictions?)
____Diabetes*	____Bone/Muscle disease	____Skin Condition	____Learning Disability
____ Scoliosis	____Vison Impairment	____Hearing Impairment	____Migraines
____ADD/ADHD	____Frequent Nose Bleeds	____ Mental Health Condition (depression/anxiety/eating disorder)	
____Other (explain)	Explain any of the above_____		

(*Current School Year Action Plan Required)

ALLERGIES:

Plants____ Animals_____ Food_____ Mold_____ Drugs_____Bees_____ Other_____

Please describe the specific allergen, reaction, and treatment for each checked allergen: _____

_____

LIFE THREATENING CONDITIONS:

Does your child have a life-threatening health condition? Yes*_____ No____ Describe: _____

MEDICATIONS:

Does your child take any prescribed medication? Yes____ No____

If Yes, Name of Medication_____ What is this prescribed for? _____

Will medication be needed or administered at school? (Inhalers, oral pills, topical ointments, injections) Yes*_____ No____

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

HEARING/VISION/SPEECH

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/contacts? Yes___No___

_____

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_____

-OVER-

It is our goal to keep our students healthy and productive while here at school. There may be times when your child is under the weather and may seek treatment in the health room to remain in school. Below are a list of over-the-counter medications that may be administered to your child by trained Health Room Staff per a standing order from the Lathrop School District advising physician. The dosages will be consistent with package instructions. **Cross through and initial any medications you DO NOT approve for use for your child this year**. You will **not** be contacted unless your child has a fever, is vomiting or is too ill to remain in class. Please indicate if you wish to be contacted when medicines are given to your child:

Stomach Pain/Upset
Generic Tums/Rolaids
Generic Pepto Bismol
Nauzene Chewable
Juice/Crackers

Headaches/Body Aches
Generic Advil (Ibuprofen)
Generic Tylenol (Acetaminophen)
Generic Excedrin (Acetaminophen/Caffeine/Aspirin)
Generic Aleve (Naproxen Sodium)

Cut/Scrapes
Triple Antibiotic Ointment
Hydrogen Peroxide
Lanacaine First Aid Spray

Itch/Insect bite relief/minor burns
Caladryl Topical
Hydrocortisone 1% topical
Aloe Vera with or without Lidocaine Topical (Burn Gel)

Cough/Cold/Allergy Season
Cough drops with menthol/eucalyptus
Generic Robitussin DM
Generic Robitussin CF (cold multi-symptom)
Generic Dimetapp
Generic Robitussin DM with Pseudoephedrine HCL decongestant (non-Drowsy)
Generic Benadryl
Cepacol lozenges/Chloroseptic spray

General Discomfort
Sweet oil for ear discomfort (not used with a history of ear tubes)
Generic Oragel or Oragel peroxide antiseptic mouth rinse (Dental/Braces/Oral discomfort)
Generic Carmex (chapped lips)

EMERGENCY ALLERGIC/ASTHMA REACTION
Epi-Pen 0.3mg/Epi-Pen Jr 0.15mg
Benadryl 25-50mg
Albuterol Nebulized Breathing Treatment 2.5mg/3ml

I give permission to the Health Room Staff to administer the above medications (unless otherwise indicated) per package dosing instructions under a standing prescription order by a Lathrop School District advising physician. **YOUR CHILD WILL NOT BE TREATED IN THE HEALTH ROOM UNLESS SIGNED.**

Signature of legal parent/guardian: _____Date:_____