Please Return to School **Osage R-3 Health Information Form** **(K-12) 20__-20__**

To: Parents/Guardian (For your child to gain the most from his/her education, it's important for the school nurse to have a current health history.)

Name_________________________________ Date of Birth___________ Male/Female Grade______

Father/Guardian_____________________________Home#_______________Work#_____________
Mother/Guardian____________________________Home#_______________Work#_____________
Other Contact_______________________________Home#_______________Work#_____________
Other Contact_______________________________ Home# _______________Work#_____________

Doctor Name_________________________________Physical exam in past year. Yes______ No______
Dentist Name__________________________________Dentist exam in past year. Yes______ No______

What type health insurance? Employer_______ Private_______ Medicaid_______ None_______

***Written permission for all medication is required. NO phone or fax permission allowed.**
My child may receive generic Tylenol as directed from the health room staff for pain relief. Yes____No____
<u>Medication taken at home</u>______________________________________Reason_______________________
<u>Medication taken at school</u>_____________________________________Reason_______________________

<u>*Please Cross Out any item that you DO NOT want to be used for/by your child .</u>

Calamine/Caladryl **Chiggerex** **Rubbing Alcohol** **Peroxide** **Hand Lotions**
Saline Solution **Allergy Eye Drops** **Petroleum Jelly** **Triple Antibiotic Ointment**
Throat/Cough drops **Alum**(for mouth sores) **Aloe Gel**

******Grade K-6 Only – I give permission for fluoride twice a year. Yes______ No_______**

MY CHILD MAY RECEIVE EMERGENCY CARE, FIRST AID AND/OR TRANSPORTED TO ____(NAME OF HOSPITAL)

I permit the school nurse to share information with the staff, as deemed appropriate by the nurse, to provide for my child's health/safety.

PARENT/GUARDIAN SIGNATURE____________________________________DATE________________

My child has the following current health concerns (put yes or no)
ASTHMA:______ If yes¸ has child been hospitalized for asthma in last 3 yrs. _____ Has child required Urgent or ER care due to Asthma in last 3 yrs. ______ Does this child take daily asthma medication ______Do they carry and inhaler_______________
ALLERGIES: To drugs, food, insects, pollens, etc. Please list____________________________________ Has the reaction ever required Emergency treatment? Yes________ No________ Has Epi Pen ever been recommended?____________________
Attention Deficit Disorder: (ADD/ADHD)____________ **Headaches:** (Describe) ________________________________
Eyes: Glasses____ Contacts____ Lazy Eye____ Date of Last Exam_______________________
Ears: Infections____ Tubes & date of placement___________ Hearing Aid____________ Other hearing problems_______________
OTHER HEALTH CONCERNS: ____

Depression_____ Bipolar_____ Anxiety_____ Nose Bleeds_____ Dental_____ Skin_____ Heart_____ Lungs_____
Bladder______Bowels_____ Orthopedic(bones/joints)______ Neurological(brain/nervous system)______
Blood Disorder_____ Blood Pressure_____Eating_____ Sleeping_____ Menstruation_____ Phobias(fears)_____

PLEASE CONTACT THE NURSE AT (573)-455-2375 EXT. 181 OR 182. IF YOUR CHILD REQUIRES ANY ACCOMMODATIONS AT SCHOOL DUE TO HEALTH REASONS.

<u>MEDICATION POLICY</u>

All medications are to be sent to the nurse in the original bottle with signed note from the parent listing the dose, time to be given and reason. Doses will not be given if they are higher than limit set in pharmaceutical literature. Over- the-counter drugs will be given only as listed on the package directions and no more than 5 times a month. If a parent wishes it to be given more often, please get a written doctor's order. If a drug is needed to treat life-threatening conditions (severe asthma, allergies), it may be carried by the student but only with doctor and parent permission.