OAK RIDGE R-VI SCHOOL DISTRICT
4198 State Highway E – P.O. Box 10 Oak Ridge, MO 63769

Student Health History

Student Name (Please Print) _____ Date of Birth: _____

Circle One: Male Female Grade Entering _____

Insurance Type: None Private Medicaid/MC+ Name of Insurance_____

Doctor/Clinic_____ Phone_____

Preferred Hospital_____

Dentist _____ Phone_____

Is your child under an orthodontist's care? Yes No Orthodontist's Name_____

My child has the following health concerns:

EYES:

Glasses Contacts

Other (Explain) _____

EARS:

Frequent Infections: Yes No

Hearing Aid(s) (Explain) _____

Hearing Difficulty (Explain) _____

ALLERGIES:

Drugs_____ **Insect**_____

Food_____ **Other**_____

Does your child require an EPI? Yes No

ASTHMA: Yes No

Has your child been hospitalized for asthma-related problems in the last 3 years? Yes No When?_____

Has this child required urgent/emergency care due to asthma in the last 3 years? Yes No When?_____

Is your child currently taking asthma medication? Yes No List meds:_____

ATTENTION DEFICIT DISORDER (ADD/ADHD): Yes No

Medications taken at home:_____

Medications needed at school: _____

DIABETES: Yes No

Doctor treating diabetes: _____ Medication: _____

HYPOGLYCEMIA: Yes No

(Over Please)

HEART CONDITION: Yes No

If yes, describe:_____

Are there any restrictions that your child must follow:_____

SEIZURES: Yes No

Date of last seizure:_____

Medication(s):_____

OTHER HEALTH CONCERNS:

Cancer Eating Disorder Sleeping Problems Bowel or Bladder Nosebleeds Skin Dental Menstruation Phobias (Fears) Blood Pressure Lungs Orthopedic Headaches Blood Disorder Neurologic Other

Explain any of the above concerns:

_____

_____

OTHER MEDICATIONS:

List any other daily medications taken at ***home*** (not previously listed) and reason for taking:

_____

_____

List any other medications taken at ***school*** (not previously listed) and reason for taking:

_____

_____

List other serious illnesses or injuries: _____

List any surgeries in the last 5 years:_____

List any special procedures your child would need at school (catheter, tube feeding, etc.):

_____

_____

PLEASE READ CAREFULLY BEFORE SIGNING

By signing, I give the school nurse permission to share this information with those staff and faculty members who will have direct contact with my child and will need to know about their medical conditions.

In the event of an illness or injury, I give permission for the district nurse or qualified assistive personnel to treat my child. Over the counter medications may be administered by the nurse or other qualified staff and as directed per the manufacturer's instructions for my child's age and weight. If my child requires this medication on a frequent basis, I may be asked to provide a bottle of his/her own to keep in the nurse's office.

In case of serious illness or accident, I request the school nurse contact me or emergency contacts listed on Enrollment Form. In case of a serious emergency or life threatening condition, I authorize the school to call emergency medical services (EMS) and to contact me as soon as possible. I give my permission for my child to receive emergency treatment considered necessary by EMS and attending physicians.

_____

Signature of Parent/Legal Guardian **Date**