Willow Springs R-IV School
Student Health Information Update
Revised 8/2013

Name ______________________________________Grade _____ Boy Girl Birth date __________________

Parents or Guardians____

Home Phone _____________________Parents Cell #'s ____

Doctor's name________________________________ Date of last check-up_______________________________

Dentist's name________________________________ Date of last check-up_______________________________

Eye doctor's name_____________________________ Date of last check up_______________________________

This student has: No insurance Private health insurance MO Health Net Medicaid

Names and ages of other children living in your home: ____

____

Does your child take medicine regularly? No Yes.

<u>If yes</u>, please list:
Medicine name: Taken for:

_________________________ ____

_________________________ ____

_________________________ ____

Will you be bringing medicine to school for this child? No Yes.

<u>If yes</u>, please list:
Medicine name: Taken for:

_________________________ ____

_________________________ ____

Medicine to be given at school must be brought to the Health Room by the parent or guardian. It must be in the original bottle with the full label. A medicine form must be signed for any medicine to be given at school.

High School students **ONLY** may carry a small amount of plain acetaminophen (also called Tylenol) in the original bottle. They must not share this with other students. <u>All other medicine must go to the Health Room.</u>

Continued on other side!

Does your child have?

*Allergies No Yes What is your child allergic to? ______________________________________

Describe the allergic reaction: ____

What is done to help the student? ____

*Asthma No Yes Does your child use an inhaler? ____________How often? ____________________

Will your child need an inhaler at school? ________ What kind? __________________________

*Diabetes No Yes Does your child take insulin or other medicine?______________________________

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*Seizures or Epilepsy No Yes What kind of seizure? _____________________________________

Date of last seizure: ______________________ Medicine:_________________________________

*Heart Condition No Yes What kind? ____

Does your child have physical limits? _________ Describe them: _________________________

*Other health problems? No Yes What are they?____

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Has your child had:

A serious illness? No Yes. What kind?____________________________________ Date:________

A serious injury? No Yes. What kind?____________________________________ Date:________

Surgery? No Yes. What Kind?____________________________________ Date:________

Childhood diseases? No Yes Which ones?__________________________________ Date:________

Does you child:

Have trouble seeing? No Yes Wear glasses or contact lenses No Yes

Have trouble hearing? No Yes Wear a hearing aid? No Yes

Today’s Date____________________Parent/Guardian Signature______________________________