

Moniteau School District

1810 West Sunbury Road, West Sunbury, PA 16061
Phone: 724-637-2117 Fax: 724-637-3862

KINDERGARTEN REGISTRATION

(District Use) Student ID No. _____ Student Start Date: _____

Student Information:

Name: _____
(Last) (First) (Middle)
Date of Birth: ____/____/____ Grade _____ Gender _____
Address: _____
City: _____ State: _____ Zip Code: _____
County: _____ Twp.: _____ Telephone: _____
Place of Birth: _____
(City and State)

Student Lives With: Both Parents _____ Father/Stepmother _____ Mother/Stepfather _____
Mother Only _____ Father Only _____ Legal Guardian _____ Foster Parents _____ (Please Provide Documentation)

Special Custodial Court Instructions:

No _____ Yes _____ (If Yes, Please Provide a Copy of Court Order)

Father/Step Father Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____

Mother/Step Mother Name: _____ Maiden Name _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address _____

If The Student Is Not Living With Parents, Please Complete This Section and Provide Paperwork

Guardian **or** Foster Parent's Name _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____

Emergency Contact: Only if a parent/guardian cannot be reached

Name _____ Phone _____

Name _____ Phone _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Former School Information:

Name of Former School_____

Address of Former School_____

Special Services: Does your child currently receive any Special Services? No_____ Yes_____ please mark

Has IEP_____ Has GIEP_____ Speech & Language_____ Chapter 15/504_____ Other_____

Ethnicity/Race: The district is required to collect ethnicity/race data in order to satisfy US Department of Education audit requirements

Ethnicity (Choose one)

_____Hispanic / Latino
_____Not Hispanic / Latino

Race (Choose all that apply)

_____American Indian or Alaskan Native
_____Asian
_____Black or African American
_____Native Hawaiian or Pacific Islander
_____White

ALL newly registering students regardless of race, nationality, or language origin MUST complete the Home Language Survey. Federal law requires that all Local Education Agencies (LEAs) utilize a non-biased procedure for identifying which students are potential English Learners (ELs) in order to provide appropriate language instruction educational programs and services. Given this responsibility, LEAs have the right to ask for the information contained on this and other forms associated with the identification process.

Home Language Survey:

- 1. Is a language other than English spoken in the child’s home? No _____ Yes____ (language)_____
- 2. Does your child communicate in a language other than English? No _____ Yes____ (language)_____
- 3. What is the language that your child first learned to speak? _____

Parent/Guardian Signature: _____ Date:_____

Is the student’s parent/guardian an active duty member of a branch of the United States Armed Forces? Yes_____ No_____

Do you have internet access? Yes_____ No_____

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Child Care Questionnaire

Child's Name _____

What was your child's educational experience prior to kindergarten?

- Head Start
- Pennsylvania Pre-K Counts
- Family Child Care
- Home-Based Care
- Relative / Neighbor Care
- Licensed Private Academic Nursery Program
- Locally Funded Pre-K Program
- School-Based Pre-Kindergarten Program
- Child Care Center
- None
- Don't know / Can't answer

Please provide name of the center / program your child attended:

SCHOOL DISTRICT STUDENT RESIDENCY QUESTIONNAIRE

Dear Parent or Guardian,



The McKinney-Vento Act, as amended by the No Child Left Behind Act of 2001, defines homelessness and outlines the rights of homeless students. Your responses to these questions will help staff determine what residency documents are necessary for enrollment of your child(ren.) Thank you for your cooperation.

1. Student name: _____ Birth Date: _____

Person completing form: _____ Relationship to child: _____

2. In what type of setting is the student living now?

Check one box below –

SECTION A	SECTION B
<p><input type="checkbox"/> In an emergency or transitional shelter</p> <p><input type="checkbox"/> Sharing the housing of other persons due to loss of housing, economic hardship, or similar reason</p> <p><input type="checkbox"/> In a motel, hotel, campsites, or cars due to a lack of alternative adequate accommodations</p> <p><input type="checkbox"/> In a car, park, public spaces, abandoned building, substandard housing, bus or train stations, or similar settings</p> <p><input type="checkbox"/> Other places not designed for, or ordinarily used as, a regular sleeping accommodations for human beings</p> <p>CONTINUE to Question 2  if you checked any box in SECTION A</p>	<p><input type="checkbox"/> None of the choices in Section A apply.</p> <div style="text-align: center;"></div> <p>If you checked this section, you do not need to complete the remainder of this form. Submit the form to school personnel now.</p>

3. Contact number for person completing the form: _____

Address where student is now living: _____

4. The student lives with:

Check all that apply

Parent(s) or legal guardian

Relative, friend(s), or other adult(s)

Alone

Other: _____

5. School student attended last : _____

Address of school: _____

Telephone number of school: _____

Contact person at school (if known): _____

6. Does the student have an IEP or a Chapter 15/504 agreement?

NO

YES. Please explain: _____

The staff person who is helping you register will contact the homelessness coordinator to review the information provided. If homelessness is verified, additional information will be needed to complete enrollment. The Homelessness Coordinator will contact you by the end of the next school day (or sooner) to share the determination regarding homeless status, to gather additional information and to discuss the plans for placement.

Signature of Parent/Legal Guardian:

Date:

NOTE TO STAFF: All forms with a checked box in Section A are to be faxed *immediately* to the Homeless Liaison to eliminate any delay.

CONSENT FORM Pre-School
Vision Screening
Please Fill Out In Full

Child's Name _____ Age _____ Sex: M ___ F ___

Address _____

City/State/Zip _____ County _____

Parent/Guardian Name (Print): _____

Phone Home (____) _____ Phone Cell (____) _____

Email Address: _____

Screening Location: _____

As the undersigned parent/guardian, I hereby grant permission to The Blind Association of Butler and Armstrong to screen the vision of the above-named child.

I understand that this procedure is a limited vision screening, designed only to detect certain symptoms of potential vision problems in children. It is not an eye examination and is not intended to take the place of a professional eye exam. **If a professional examination is recommended**, I give my consent to permit The Blind Association of Butler and Armstrong to obtain information, from the examining eye specialist, regarding my child's eye examination and recommended treatment, and to furnish such information, as needed, to the appropriate school/ agency. I also understand that follow-up is required and that I may be contacted by the agency for further information.

Parent/Guardian Signature: _____ Date: _____

Has your child had a professional eye Examination? YES () NO ()

CHECK ALL THOSE THAT APPLY:

- Wears glasses Shuts or covers one eye Squints at objects
 Complains about eyes Tilts or thrusts head forward Holds objects close to eyes
 Blinks more than usual Rubs eyes excessively
 Either eye turns in, out, up or down (which one?) _____

Family history of eye problems (specify): _____ Other observations (describe): _____

Thank you, The Blind Association of Butler and Armstrong, 724-287-4059

For Office Use Only

Referred: Yes ___ ID # _____ No ___ C B H A NA O (circle one)

Please check any of the following **medical problems** that your child has **ever** had.

Ear infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nose problems (sinus infections, nose bleeds)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye problems (blurry vision, need to wear glasses)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mouth or throat problems (Strep throat, swallowing problems)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea (having frequent and runny bowel movements)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation (problems having a bowel movement)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Throwing up (vomiting)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Problems peeing (bed wetting, pain when peeing)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back problems (crooked back, back pain)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Growing pains (bone or body pains due to growing)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscle and bone problems (weak muscles, pain in joints)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skin problems (acne, flaking skin, rashes, hives)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures (shaking fits)	<input type="checkbox"/> Yes <input type="checkbox"/> No
ADD/ADHD (problems paying attention, sitting still)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleeping problems (falling or staying asleep)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing problems (cough, asthma)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No
Warts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Jaundice (yellow skin)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Can the child use the toilet without help? YES _____ NO _____

ABOUT MOM WHEN PREGNANT

The following questions are about the mother of the child during pregnancy and birth.

What was the general **health of the mother** during pregnancy?

- Excellent Good Fair Poor Unknown

Did the mother take any medications (other than iron or vitamins) **during the pregnancy?**

- Yes
 No

Did the mother have any of the following **conditions or problems during pregnancy?**

- Preeclampsia (high blood pressure) Diabetes
 Emotional stress Other
 Injury or serious illness none of the above

Was the birth:

- On the due date
 Before the due date -by how much _____
 After the due date -by how much _____

What was the baby's birth weight? _____

ABOUT THE CHILD AS A BABY

In the first **6 months after birth**, did the child have:

- Jaundice (yellow skin)
 Colic (upset stomach, crying)
 Breathing problems
 Other _____
 None of the above

At what age did the child begin to **crawl**? _____

At what age did the child begin to **sit up**? _____

At what age did the child begin to **walk**? _____

At what age did the child begin to **say two or three words** together? _____

Please list what your child typically **eats and drinks in a day** for:

- Breakfast-
- Lunch-
- Dinner-
- Snacks-

Do you have additional concerns about the child that you would like to share? (Shy, sad, temper tantrums, disobedience, property destruction, stuttering, thumbsucking, bowel concerns, wetting during the day, feeding, nightmares, fighting with other children, restless, easily upset, day dreams, stubborn, etc.)

FAMILY

Check all the people that the **live in the household with the child**:

- Mother
- Father
- Brothers (how many?) _____
- Sisters (how many?) _____
- Other family members (list)
- Friends or other people (list)

What medical problems do people in the child's family have?

Mother	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Learning difficulty
	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma /Wheezing
	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Allergies/Eczema
	<input type="checkbox"/> Seizures	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Blood disorder
	<input type="checkbox"/> Other _____		

Father	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Learning difficulty
	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma /Wheezing
	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Allergies/Eczema
	<input type="checkbox"/> Seizures	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Blood disorder
	<input type="checkbox"/> Other _____		

Siblings	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Learning difficulty
	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma /Wheezing
	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Allergies/Eczema
	<input type="checkbox"/> Seizures	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Blood disorder
	<input type="checkbox"/> Other _____		

Have any members of the immediate family died? Yes No

If so, who? _____



Moniteau School District

Authorization for Prescription Medicine

During School Hours

I am requesting my child receive the following prescribed medication during school hours in order to maintain sufficient health to participate in the school program.

Child's Name: _____

Homeroom: _____

Name of Medication: _____

Purpose of medication: _____

Time to be administered: _____

Dosage with any special instructions: _____

Possible side effects: _____

Procedure to follow if reaction should occur: _____

Termination date for administering medication: _____

I hereby authorize the medication listed above to be administered to my child by the school nurse or other school employee. I do hereby release, discharge and hold harmless the Moniteau School District, its agents and employees, from any and all liability and claim whatsoever for the administration of the above medication to my child/ward should there develop an allergic or other reaction from the medication.

Signature of Parent/Guardian

Date



Dassa McKinney Elementary School

Moniteau School District

391 Hooker Road, West Sunbury, PA 16061
724-637-2321 FAX: 724-637-3877

Dear Parent or Guardian,

The following information explains the physical examination requirements established by the Pennsylvania Department of Health. These regulations apply to all school aged children.

The Department of Health mandates that a complete physical examination be given to all children upon original entry into school (kindergarten or first grade), along with grades six and eleven. A complete dental examination is also required upon entrance to school and in grades three and seven.

As in previous years, the law and Health Department policy provides for the use of family physicians and dentists in performing these required examinations, should it be the wish of the parents. Forms for having the examinations completed by the family physician or dentist during the summer are attached. If these forms are not returned before the exam is scheduled in school, your child will be examined by the school physician or nurse practitioner and the school dentist. Any private physical or dental examination that is given within six months of the start of school will be accepted.

Your prompt attention to this letter and the attached examination forms are appreciated. If you have any questions concerning these examinations, please contact the school nurse.

Sincerely,

Ms. Leslie Fallen, RN, BSN, CSN
School Nurse

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

**PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE**

NAME OF SCHOOL _____ DATE _____ 20__

NAME OF CHILD			AGE	SEX	GRADE	SECTION/ROOM
Last	First	Middle		<input type="checkbox"/> M <input type="checkbox"/> F		

ADDRESS

No. and Street City or Post Office Borough/Township County State Zip

REPORT OF EXAMINATION

	TOOTH CHART																
	RIGHT								LEFT								
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
UPPER				A	B	C	D	E	F	G	H	I	J				Upper
LOWER	32	31	30	T	S	R	Q	P	O	N	M	L	K	19	18	17	Lower
UPPER																	Upper
LOWER																	Lower

Is The Child Under Treatment? Yes No

Treatment Completed Yes No

Date of Dental Examination

Signature of Dental Examiner

Print Name of Dental Examiner

Address



Bureau of Community Health Systems
Division of School Health

**Private or School
PHYSICAL EXAMINATION
OF SCHOOL AGE STUDENT**

PARENT / GUARDIAN / STUDENT:

Complete page one of this form before student's exam. Take completed form to appointment.

Student's name _____ Today's date _____

Date of birth _____ Age at time of exam _____ Gender: Male Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

Does the student have any allergies? No Yes (If yes, list specific allergy and reaction.)

Medicines Pollens Food Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: <i>Has the student...</i>	YES	NO
1. Any ongoing medical conditions? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infection Other _____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: <i>Has the student...</i>	YES	NO
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: <i>Has the student...</i>	YES	NO
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: <input type="checkbox"/> Heart murmur or heart infection <input type="checkbox"/> High blood pressure <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other: _____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: <i>Has the student...</i>	YES	NO
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: <i>Has the student...</i>	YES	NO
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: <i>Has the student...</i>	YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. FEMALES ONLY: Had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	YES	NO
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> greater than 2 years		
SOCIAL/LEARNING: <i>Has the student...</i>	YES	NO
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	YES	NO
42. Is there a family history of the following? If so, check all that apply: <input type="checkbox"/> Anemia/blood disorders <input type="checkbox"/> Inherited disease/syndrome <input type="checkbox"/> Asthma/lung problems <input type="checkbox"/> Kidney problems <input type="checkbox"/> Behavioral health issue <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Sickle cell trait or disease Other _____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: <input type="checkbox"/> Brugada syndrome <input type="checkbox"/> QT syndrome <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Marfan syndrome <input type="checkbox"/> High blood pressure <input type="checkbox"/> Ventricular tachycardia <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other _____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	YES	NO
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student _____ Date _____

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFORMING EXAMINATION: Yes No

Physical exam for grade: K/1 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other <input type="checkbox"/>	CHECK ONE			*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
	NORMAL	*ABNORMAL	DEFER	
Height: () Inches				
Weight: () pounds				
BMI: ()				
BMI-for-Age Percentile: () %				
Pulse: ()				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected <input type="checkbox"/>				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION
 (Additional space on page 4)

Parent/guardian present during exam: Yes No

Physical exam performed at: Personal Health Care Provider's Office School Date of exam _____ 20____

Print name of examiner _____

Print examiner's office address _____ Phone _____

Signature of examiner _____ MD DO PAC CRNP

HEALTH CARE PROVIDERS: Please photocopy immunization history from student's record – OR – insert information below.

IMMUNIZATION EXEMPTION(S):

Medical Date Issued: _____ Reason: _____ Date Rescinded: _____
 Medical Date Issued: _____ Reason: _____ Date Rescinded: _____
 Medical Date Issued: _____ Reason: _____ Date Rescinded: _____

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician <input type="checkbox"/>	Date: _____				
Varicella: Vaccine <input type="checkbox"/> Disease <input type="checkbox"/>	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) I.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

MONITEAU SCHOOL DISTRICT
CONFIDENTIAL EMERGENCY HEALTH INFORMATION FORM

Student's Name: _____ Age: _____ D.O.B.: _____ Grade: _____
Address: _____ Home Phone: (_____) _____
_____ Email Address: _____

Student Lives With:

Please list name(s) and grade(s) of sibling(s) who attend Moniteau School District:

1) _____ Gr. _____ 2) _____ Gr. _____ 3) _____ Gr. _____

Mother/Guardian's Name: _____ Cell Phone: (_____) _____

Place of Employment: _____ Work Phone: (_____) _____

Father/Guardian's Name: _____ Cell Phone: (_____) _____

Place of Employment: _____ Work Phone: (_____) _____

*In case of an illness and the school nurse is unable to reach the contacts listed above, please call the following contacts who will assume responsibility/transportation for my child:

Name: _____ Relationship: _____ Phone #: (_____) _____

Name: _____ Relationship: _____ Phone #: (_____) _____

**If there is someone your child should not be dismissed to, note here _____

Does your child have health insurance? ___ No ___ Yes

Medical Insurance Carrier: _____ Policy Number: _____

I understand that in a life threatening situation, the school district is required by law to transport my child to the nearest hospital.

Physician's Name: _____ Phone # (_____) _____

Dentist's Name: _____ Phone # (_____) _____

I give the school nurse permission to give my child the following medication, if needed, during school hours. (Please check) If these are not checked and signed by parent/guardian, the medications will not be administered to your child.

___ Tylenol ___ Ibuprofen ___ Benadryl ___ TUMS ___ Eye Drops ___ Pepto-Bismol

Parent/Guardian's Signature

Date

*** Please turn over and complete the reverse side of this form. ***

**MONITEAU SCHOOL DISTRICT
HEALTH HISTORY FOR SCHOOL NURSE**

TO HELP ME KNOW YOUR CHILD BETTER AND PROVIDE NECESSARY CARE, PLEASE COMPLETE THE FOLLOWING:

PLEASE CHECK THE FOLLOWING CONDITIONS THAT PERTAIN TO YOUR CHILD:

____ Asthma
____ Inhaler: _____
(Name of inhaler)

____ ADD / ADHD
____ Medication: _____

____ Allergy:
____ Food: _____
____ Medication: _____
____ Insect: _____
EPI-PEN Required: ____ yes ____ no

____ Celiac Disease / IBS (circle)
____ Convulsions / Epilepsy / Seizures (circle)

____ Diabetes

____ Head injury/concussion
Date: _____

____ Hearing Defect
____ Hearing aids

____ Heart Condition

____ Hospitalization
Date(s) : _____
Reason: _____

____ Migraines
Rx Medication: _____

____ Orthopedic Problems

____ Psychological Problems (depression, anxiety)

____ Vision Deficit (Distance / Reading)
____ Glasses
____ Contacts

____ Other

1. Does your child have a condition that requires regular medication? ____ Yes ____ No
If yes, please list all daily medication(s) and time taken: _____

2. Is your child presently under the care of a physician? _____
If yes, please explain. _____

3. Are there any restrictions of activities? _____

* If your child has a condition or health issue that is not mentioned on this form, please attach a separate piece of paper to this form explaining details. This side of the form is confidential and will remain in the Nurse's Office.

*** Please turn over and complete the reverse side of this form. ***