MONITEAU SCHOOL DISTRICT

CONFIDENTIAL EMERGENCY HEALTH INFORMATION FORM

2024-2025

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 <u>should not</u> 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 ***<u>not</u>*** checked and signed by parent/guardian, the medications ***<u>will not</u>*** 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

Mrs. McEwen, High School Nurse **Mrs. Fallen, Dassa McKinney 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: _____
(Name/dosage/time)
____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: _____
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 <u>all</u> 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. *****