SEYMOUR R-II SCHOOLS STUDENT HEALTH INVENTORY
SCHOOL YEAR: 2021-2022

Please Print **Grade/Teacher _____ / ________________________________**

School: *(check one)* □ **High School** □ **Middle School** □ **Elementary** □ **Preschool**

Student's Name ______________________________ Birth Date _______________ □Male □Female

Parent/Guardian: ______________________________ Phone: ________________ Employer: ____________________

Parent/Guardian: ______________________________ Phone: ________________ Employer: ____________________

Emergency Contact Other than Parent: ______________________________ Phone: ___________________________

Medical Information:

Type of Insurance: □ None □ Private □ Medicaid/MC+/Mo Health Net

Where do you take your child to seek medical care?

□ No Regular Source □ Emergency Room □ Physician/Clinic/Primary Care Provider

Doctor/Clinic: __________________________ Phone ________________ Last Physical Exam: ______________

Dentist: _______________________________ Phone _________________ Last Dental Exam: ______________

Hospital Preference: ____

IN CASE OF AN EMERGENCY AND YOU CANNOT BE REACHED, YOUR CHILD WILL BE TRANSPORTED TO THE HOSPITAL AT YOUR EXPENSE .

Does your child have a diagnosis confirmed by a doctor of:

Asthma /Non-medicated □Yes □No Trigger: ____________________ Treatment: ______________________

Asthma/Medicated □Yes □No Trigger: ____________________ Treatment: ______________________

Severe Insect Allergy □Yes □No Specify Insect/Reaction: ___________________ Treatment: __________________

Food Allergies □Yes □No Specify Food/Reaction: ___________________ Treatment: __________________

Hay Fever □Yes □No Treatment: ____

Other Allergies □Yes □No Specify: ____

Ear Tubes □Yes □No Date: ____

Type 1 Diabetes □Yes □No Medication: ____

Type 2 Diabetes □Yes □No Medication: ____

Migraines □Yes □No Treatment: ____

Heart Condition □Yes □No Specify: ____

Kidney/Bladder Disorder □Yes □No Treatment: ____

Nosebleeds (frequent) □Yes □No Treatment: ____

Hearing Problems □Yes □No Hearing Aids Required: □Yes □No

Vision Problems □Yes □No Glasses: □Yes □No Contacts: □Yes □No Last eye exam: __________

Attention Deficit Disorder □Yes □No Medication: ____

Attention Deficit Hyperactivity □Yes □No Medication: ____

Autism □Yes □No Specify: ____

Behavior Disorder □Yes □No Specify: _________________________ Treatment: _________________

Mental/Emotional Disorder □Yes □No Specify: _________________________ Treatment: _________________

Seizures □Yes □No Specify: ____

Date of last seizure: ________________ Medication ______________________________

Other diagnoses not listed □Yes □No Specify: ____

Does your child have a special health care need: □ **Yes** □**No** Specify: ______________________________

Does your child have a condition that might limit PE participation: □ **Yes** □**No** Specify: ___________________

Does the special health care need require special equipment or arrangements? □ **Yes** □ **No**

Additional Comments: ____

PLEASE DON'T FORGET THE BACK!!!

Has your child had a serious:

Illness □Yes □No Specify: ____

Injury □Yes □No Specify: ____

Surgery □Yes □No Specify: ____

Hospitalization □Yes □No Specify: ____

Does your child take medication: □ Yes □ No

Name of Medication __________________ How often: ______________ For: ______________

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Will your child need to take medication while at school? □ Yes □ No

Name of Medication __________________ Dosage: ______________ Time: ______________

Name of Medication __________________ Dosage: ______________ Time: ______________

Name of Medication __________________ Dosage: ______________ Time: ______________

If your child requires medication to be given during school hours, please contact the nurse for required paperwork that must be completed **BEFORE** any medication can be given at school. Per school policy, students should not carry **ANY** medication during school hours unless approved by the school nurse.

Over-the-Counter Medications: Standing orders by a local physician allow the school nurses to provide the following medications to students according to nursing judgement. A doctor's order is required for medication administration outside of the standing orders. Standing orders may be updated as needed throughout the school year. Please mark through any of the following medications you do **NOT** wish your child to have.

Ibuprofen: For minor aches and pains, headache, backache, earache, toothache, premenstrual/menstrual cramps. Not for fever. May not exceed more than 1 dose daily or 2 consecutive daily doses without further evaluation and written order from family physician.

Acetaminophen: For minor aches and pains, headache, backache, earache, toothache, premenstrual/ menstrual cramps. Not for fever. May not exceed more than 1 dose daily or 2 consecutive daily doses without further evaluation and written order from family physician.

Anbesol/Orajel: for the temporary relief of pain associated with toothache, sore gums, canker sores, braces, minor dental procedures, and dentures.

Antacid: to relieve heartburn, sour stomach, acid indigestion, or upset stomach associated with these symptoms.

Antibiotic Ointment: to prevent infection in minor cuts, scrapes, and burns.

Benadryl/Diphenhydramine HCL: Hives and/or allergic reactions not severe enough for epinephrine with parent approval.

Caladryl/Calamine: for the temporary relief of pain and itching associated with minor skin irritations and rashes due to point ivy, poison oak, or poison sumac.

Contact Solution/Contact Eye Drops: for use when requested for contacts.

Cough drop/Throat Lozenges: 1 every hour as needed for cough or sore throat, not to exceed 3 daily.

Hydrocortisone 1% cream: for the temporary relief of itching associated with minor skin irritations and rashes.

Salt Water Gargle: 1/4-1/2 teaspoon salt dissolved in 8 ounces of water for sore or scratchy throat.

Sterile Eye wash: to help flush loose foreign material or chemicals from the eyes. To help relieve eye irritation, burning, itching, and stinging by removing air pollutant (smog or pollen) or chlorinated water.

Vaseline/Petroleum Jelly: for the temporary relief of chapped lips or skin.

Sharing of Medical Information: To provide the best care possible to your child while at school, it may be necessary to communicate some aspects of your student's health information to other school staff. It may also be necessary to communicate with your child's medical provider(s).

Parent/Guardian's Name: ______________________________ **Phone:** ______________________

Parent/Guardian's Signature: ______________________________ **Date:** ______________

Parent/Guardian's Email Address: ____

Revised: 2/2020