Richards R-V School
Student Health Information Update
Revised 04/2019

Name: _____ Grade: _____ Gender: _____ DOB: _____
Parent(s) or Guardian(s): _____ Home Phone: _____
Work and/or Cell Phones: _____
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 HealthNet __ Medicaid __

Does your child:
Have trouble seeing? No __ Yes __ Wear glasses? No __ Yes __ Wear contact lenses? No __ Yes __
Have trouble hearing? No __ Yes __ Wear a hearing aid? No __ Yes __

Does your child take medicine (over-the-counter or prescription) regularly at home? No __ Yes __
If yes, please list:

Name: _____ Dosage: _____ Reason taken: _____
_____ _____ _____

Will your child be taking routine/daily medicine at school? No __ Yes __
If yes, please list:

Name: _____ Dosage: _____ Reason taken: _____
_____ _____ _____

*** Medicine to be given at school must be brought to the nurse's office by the parent or guardian. It must be in the original bottle with the prescription label attached. Ask the pharmacy for a second bottle when filling any prescription medicine to be given during school hours. The parent or guardian must sign a form for any medicine to be given at school. ***

Does your child have:

Insect Sting Allergy: No __ Yes __ Describe reaction: _____
Difficulty breathing: No __ Yes __ Emergency medication: No __ Yes __
Does child have any Epi-Pen? No __ Yes __If yes, please bring to school.

Allergies: No __ Yes __ What is child allergic to (drugs, food, environmental allergens)? List: _____
_____
Describe reaction: _____
Has allergy required emergency action in the past? No __ Yes __
Does child have any Epi-Pen? No __ Yes __ If yes, please bring to school.

Asthma: No __ Yes __ Triggered by: _____ Treatment/Medication: _____
Diagnosed by doctor: No __ Yes __ Date diagnosed: _____
Does child use a rescue inhaler? No __ Yes __ If yes, please bring to school.

Diabetes: No __ Yes __ Taking insulin: No __ Yes __ Other medication: _____
Diagnosed by doctor: No __ Yes __ Date diagnosed: _____

Epilepsy/Seizures: No __ Yes __ Type of seizure: _____
Date of last seizure: _____ Medication: _____
Currently under a doctor's care for seizures? No __ Yes __
If so, doctor's name: _____

Heart Condition: No __ Yes __ Describe: _____
Any physical restrictions: _____ Medication: _____

Bone/Joint Problem: No __ Yes __ Describe: _____
Any physical restrictions: _____ Medication: _____

Mental Health: No __ Yes __ Describe: (i.e. ADD/ADHD, anxiety/depression, mood disorders, emotional/psychiatric problems) _____
Diagnosed by doctor: No __ Yes __ Date diagnosed: _____
Counselor/Caseworker: No __ Yes __ If so, counselor's name: _____
Medication: _____

Other Illness, Injury or Surgery: No __ Yes __ Describe: _____

Special Education or Services student receives: IEP__ OT__ PT__ Speech/Language__ Counseling__
Requires special health care (explain): _____

Parent Permission to Administer Over-the-Counter Medications

Please indicate which of the following medications for which you are giving permission to be administered:

____ **Acetaminophen** (Tylenol). Administered every 6 hours at the manufacturer's recommended dosage for pain or fever.
____ **Antacid** (Tums). One or two routine doses per day for heartburn, indigestion or upset stomach.
____ **Calamine lotion**. For irritated, itchy skin associated with poison ivy, oak or sumac.
____ **Campho-phenique**. For minor skin wounds and insect bites/stings.
____ **Hydrocortisone Cream**. Up to three times daily for minor skin irritation, inflammation or rashes.
____ **Eye Drops**. For dry eyes.
____ **Salt Water Gargle**. One teaspoon of salt to four ounces of water for gargle and spit every four hours as needed for sore throat or canker sores.
____ **Skin Wounds**. Cleanse with soap and water/peroxide and apply antibiotic ointment and dressing.
____ **Splinters**. Remove splinters aseptically.
____ **Sunscreen**. Apply as needed prior to sun exposure.
____ **Vaseline**. For chapped lips as needed.
____ **Cough drop**. One to two per day as needed for cough or throat irritation.

Signature of Parent or Guardian: _____ Date: _____