OTTERVILLE R-VI STUDENT HEALTH ENROLLMENT

GRADE: _____

(A current health enrollment form must be completed by a parent annually at the beginning of the school year. All students are required to have the completed form on file before being allowed to participate in any school field trips.)

Student's Name: _____
(Last) (First) (Middle)

Gender: _____ Race/Ethnicity: _____ Birth date: _____

Is English the primary language spoken in the home? YES NO County Resides In: _____

Student Lives With: _____Other children at home? _____

Your child's learning depends upon good health. To assist in providing health services at school, please complete:

Does your child have?

Allergies No____Yes_____ To drugs, food, insects, pollen? Please list_____

Has the allergy required emergency action in the past?Yes____NO____

Comments_____

*****Food allergies require documentation from a doctor for substitutions.**

Asthma No____Yes_____Triggered by _____

Treatment_____

Diagnosed by a doctor: _____Date:_____

******Please note- your child MAY carry an inhaler with him/her, however a written doctor's order is required.**

Diabetes No____Yes_____ Takes insulin? No____Yes_____ Date Diagnosed:_____

Seizures No____Yes_____ Describe seizure_____

Date of last seizure_____Medication_____

Is student currently under a doctor's care for seizures? _____

Doctor's Name_____

Heart/Lung Problems NO_____Yes_____

Any physical restrictions?_____

Bone/Joint Problems No_____Yes_____ Describe_____

Any physical restrictions?_____

Bowel/Bladder Problems No_____Yes_____Describe_____

Any physical restrictions?_____

Mental Health Good_____ Under Care for: _____

On medication: _____No _____Yes, please list: _____

List current or past treatments_____

Eye Problems No_____Yes_____Describe_____

Does student require glasses/contacts?_____

Ear Problems No_____Yes_____Describe_____

Does student require hearing aids/devices?_____

Does student have tubes in ears?_____

Dental Problems No_____Yes_____Describe_____

Please list CURRENT childhood diseases, serious illness, or injury?

_____

_____

Does your child take medications at home?No____Yes_____At School?No_____Yes_____

List medications: _____

_____

PAST history of any childhood disease, major illnesses, hospitalizations, or surgeries:

_____

_____

Doctor's Name:_____Phone Number: _____
Dentist's Name: _____Phone Number: _____
Eye Specialist: _____Phone Number: _____
Is your child covered by any medical insurance?(circle) YES NO
List insurance carrier: _____
Has your child been seen by a doctor for a comprehensive exam within the last year? _____
Has your child been seen by a dentist within the last year? _____
Has your child been seen by an eye specialist within the last year? _____

HEALTH CARE ACTION PLAN

(Complete section for students with special health concerns requiring ACTIONS!!!)

The goal of the Otterville R-VI School District is to anticipate, minimize and/or prevent situations or problems, which place the child in jeopardy. In order to provide your child with the best care concerning his/her condition, it is important to have a plan of action in the event of an instance involving the above-mentioned condition. I have listed my child as having the following health condition,
_____.

Additional person(s) other than what is written on the other side whom may be contacted in an emergency regarding child's medical condition:

Name: _____	*Name:* _____
Relationship: _____	*Relationship:* _____
Phone Number: _____	*Phone Number:* _____
Work Number: _____	*Work Number:* _____

Hospital Preferred: _____ *(EMS determines the closest available to provide care.*

List any special instructions to follow concerning your child's health condition:

If your child's condition requires that he/she take any medication, it is important that it is placed in the health office in the event of an emergency. A physician's written order is required for all medications kept and dispensed from the school health office. Parents must provide the school with the appropriate medication. Please list the medication and any special instructions to follow:

In the event that my child is injured or becomes ill and/or needs medical attention for any reason whatsoever, and (I) (we) cannot be contacted, this Authorization will serve as (my) (our) request and authority for the school authorities to activate an emergency medical service for the purpose of conveying my child to the hospital, doctor, or to the proper Medical Facility and that (I) (we) shall authorize any and all medical treatment provided to my child. (I) (We) fully understand that (I) (we) shall be responsible for all costs of ambulance service and any and all medical care and/or treatment provided to my child in case of an emergency.

Signature of Parents/Guardians_____Date_____