STUDENT HEALTH FORM

STUDENT NAME ____GRADE ______SCHOOL_______________

PRIMARY CARE PHYSICIAN:___________________________________PHONE#: ___________________________
DENTIST:____PHONE#:_________________________________
MEDICAL INSURANCE (circle): **PRIVATE** **HMO** **PPO** **MC+**

The Harrisonville School District participates in and receives reimbursement from agencies that are connected with Medicaid. This Process requires that we submit student information to these programs. If you do not wish to have information on your child shared with these programs check here______.

MEDICAL HISTORY: DOES YOUR CHILD CURRENTLY HAVE ANY OF THE FOLLOWING?

- ☐ ASTHMA
- ☐ SEIZURES
- ☐ AUTISM
- ☐ ADHD
- ☐ BIPOLAR
- ☐ BLEEDING DISORDER
- ☐ DIABETES (INSULIN OR PILLS)
- ☐ CHRONIC BOWEL/BLADDER ISSUES
- ☐ MIGRAINES OR FREQUENT HEADACHES
- ☐ HIGH BLOOD PRESSURE
- ☐ ODD
- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ STOMACH ULCERS
- ☐ FREQUENT NOSE BLEEDS

Other Condition(s):___________________________Explanation:________________________________
Daily Medication Needed At School:____

DO YOU BELIEVE YOUR CHILD HAS A DISABILITY THAT SUBSTANTIALLY LIMITS A MAJOR LIFE ACTIVITY? Y / N
If yes please explain:____

ALLERGIES / EPI-PEN USE

- ☐ Food Allergy____
- ☐ Medication Allergy____
- ☐ Wasp/Bee Sting Allergy____
- ☐ Other Allergies____
- ☐ Requires Epi-Pen (Parent to bring prescription labeled Epi-Pen & fill out MAR for school use.)
- ☐ My child **CANNOT** receive epinephrine (Epi-Pen) even when trained personnel believe he/she is having a life-threatening anaphylactic reaction.

*****MCEOWEN, HMS and HHS PARENTS*****

The following over the counter medications are in generic pill form and available to MCE, HMS, and HHS students. Please *initial* next to each medication your student may be given while at school if it is needed. ***If the line is left blank, it will be assumed that the medication is not to be given to your student. I further understand that nursing staff will follow package directions. Parent will be notified if taken frequently and medication (in its unopened original container) will need to be brought in by a parent or guardian for the student at that time.***

TYLENOL _________ IBUPROFEN ________ TUMS ________

Parent/Guardian Signature____________________________________Date________________________

NO CHANGES

_______________________Date_______ ____________________Date_______ ______________________Date_______

_______________________Date_______ ____________________Date_______ ______________________Date_______

_______________________Date_______ ____________________Date_______ ______________________Date_______

_______________________Date_______ ____________________Date_______ ______________________Date_______

(Revised 5-22-13)