

WINFIELD R-IV SCHOOL DISTRICT

Confidential Student Health Profile/Assessment

Student Name: _____ Grade: _____ Date of Birth _____/_____/_____

****Does Your Child Have:** (Please Circle Response and Fill out Applicable Information)

Allergies to Medication: No Yes Drug Name: _____
 Date of Last Reaction _____ Type of Reaction _____ Treatment: _____

Allergies to Food: (MARK ONLY IF VERIFIED BY A PHYSICIAN)
 No Yes Please List: _____
 Date of Last Reaction _____ Type of Reaction _____ Epi Pen: Yes No

*****If your student needs a Meal Modification, please contact the Food Service Director at (636) 668-6848*****
****Parent/Guardian will supply the school district with emergency Epinephrine/ Medication for known severe allergy****

Allergies to Bee Stings: No Yes Please List: _____
 Date of Last Reaction _____ Type of Reaction _____ Epi Pen: Yes No

****Parent/Guardian will supply the school district with emergency Epinephrine/ Medication for known severe allergy****

Allergies to Latex or other Known Allergies: No Yes Last Reaction _____ Type _____ Treatment _____

Asthma No Yes Treating Doctor Name: _____ Phone #: _____-_____-_____

Asthma History and Needs Assessment:

At what age was your child diagnosed with Asthma? _____
 What are the signs and symptoms that signal a flare up of your child's asthma? _____

****If your child has not had an asthma attack or required medical treatment of medication in over a year, you may skip the questions below. However, if your child has had asthma symptoms in the last year, please answer the questions below. ****

In the past 4 weeks, did your child:

- | | | | |
|--|-----|----|----|
| 1. Have wheezing or difficulty breathing when exercising? | Yes | or | No |
| 2. Have wheezing during the day when <u>not</u> exercising? | Yes | or | No |
| 3. Wake up at night with wheezing or difficulty breathing? | Yes | or | No |
| 4. Miss days of school because of his/her asthma? | Yes | or | No |
| 5. Miss any daily activities (such as playing, going to a friend's-house, or any family activity) because of asthma? | Yes | or | No |
| 6. Does your child use an inhaler or a nebulizer for quick relief from asthma symptoms? | Yes | or | No |

If Yes, in the past 4 weeks, what was the greatest number of times in **1 week** your child has had to use their inhaler/nebulizer?
 ___0 ___1-2 ___3-4 ___5-6 ___more than 6

- | | | | |
|---|-----|----|----|
| 7. Do you believe that your child's asthma was well controlled in the last 4 weeks? | Yes | or | No |
| 8. Does your student require rescue inhaler/medication at school? | Yes | or | No |

PLEASE INITIAL: _____

Diabetes No Yes Treating Doctor Name: _____ Phone #: _____-_____-_____

Seizures No Yes Type: _____ Date Last Seizure: _____

Migraines No Yes Treating Doctor Name: _____ Phone #: _____-_____-_____
 Type: _____ Treatment: _____ Known Triggers: _____

Skin Conditions No Yes Type: _____ Treatment: _____

Orthopedic Problems No Yes Type: _____ Treatment/Aid: _____

Heart Condition No Yes Specify: _____

Has your Student had any **recent** serious illnesses or hospitalizations? No Yes Reason: _____

Other Illness, injury or Health problem which might affect performance at school or require special attention?

HIV _____ Hepatitis B _____ Other (List) _____

****Does Your Child Have:** (Please Circle) 504 Plan Yes No Individual Education Plan ((IEP) Yes No

Is Your Child Treated For: (Please Circle)?

ADD / ADHD Yes No
Bipolar Yes No
Mood Disorder Yes No
Depression Yes No
Panic Disorder Yes No
Anxiety Disorder Yes No
Schizophrenia Yes No
Obsessive Compulsive Disorder (OCD) Yes No
Obsessive Defiant Disorder (ODD) Yes No

Does Your Child Currently Take Any Medications?

Home: Name: _____ Dosage: _____ Frequency: _____
Name: _____ Dosage: _____ Frequency: _____
Name: _____ Dosage: _____ Frequency: _____
Required at School: Name: _____ Dosage: _____ Frequency: _____
Name: _____ Dosage: _____ Frequency: _____

Has Your Child Had: (Please Circle)

Chickenpox No Yes at What Age: _____ Mumps No Yes at What Age: _____
Measles No Yes At What Age: _____
←←←← Please fill out reverse side →→→→

Does Your Child: (Please Circle)

Wear Glasses: No Yes Contact Lens: No Yes
Have Trouble Hearing: No Yes Wear a Hearing Aid: No Yes
Cochlear Implant: No Yes

*In case of emergency, school authorities will use their own judgment in seeking the best treatment. In this event, parents will be contacted at the earliest possible time. Parents who do not wish their child cared for in accordance with this statement should indicate this in writing to:
Superintendent of Schools, 100 8th Street, Winfield, MO 63389*

Please Initial _____

I understand that should an emergency vehicle be requested by School Authorities to transport my Son/Daughter, it is my responsibility to pay for the emergency vehicle and treatment. Also, the information contained herein is accurate to the best of my knowledge.

Please Initial _____

I/We agree that the above information may be shared with other faculty / staff / or health care provider as is deemed necessary by the school nurse in accordance with Federal Confidentially Regulations (HIPPA). I hereby authorize the school to contact the physician indicated above and follow his / her directions.

Local Physician's Name & Telephone Number:

Physicians Name: _____ Address: _____
Telephone Number: _____

OVER-THE COUNTER MEDICATION: *The school has this "Standing Physician Order" form for specific medications. For your student to receive the listed of medication(s) on the Standing Physician Order, the parent/legal guardian must sign the form and it must be on file in the nurse's office. If you wish for your student to receive any over-the-counter medications NOT listed on the "Standing Orders" form, you must have the Medication Consent Form written consent signed, and you must provide the medication in the original container.*

Signature of Parent/Guardian: _____ Date: _____

IT IS THE PARENT'S RESPONSIBILITY TO REPORT CHANGE OF NAME, ADDRESS, TELEPHONE, HEALTH CONDITIONS AND ANY OTHER PERTINENT INFORMATION TO THE SCHOOL OFFICE.