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 No Yes Please List:_____
Date of Last Reaction _____Type of Reaction_____ Treatment:_____

Allergies to Bee Stings No Yes Please List; _____
Date of Last Reaction _____Type of Reaction _____Treatment:_____

Asthma No Yes Treating Doctor Name:_____ Phone #:____-____-_____
*****If you circled *Yes*, Please fill out the information on the reverse side***********

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

Seizures No Yes Type:_____ Date Last Seizure:_____
Treating Doctor Name:_____ Phone #:____-_____-_____

Heart Condition No Yes Specify:_____
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:_____
Require at School: Name:_____Dosage:_____Frequency:_____
Name:_____Dosage:_____Frequency:_____

*****(The school District requires a written request from the Doctor and the Parents in order to dispense medication)***

Has Your Child Had: (Please Circle)

Chickenpox No Yes---At What Age:_____ **Mumps** No Yes---At What Age:_____
Measles No Yes ---At What Age:_____

Does Your Child: (Please Circle)

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

←←←← ***Please fill out reverse side if applicable*** →→→→

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 <u>past 4 weeks,</u> 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

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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, 701 Elm, 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 or staff 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.

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.

05/2014 kml /lk