NODAWAY-HOLT RVII
HEALTH INVENTORY

STUDENT NAME: ________________________________ GRADE _________________

BIRTHDATE: ____________________________________ AGE ____________________

MOTHERS NAME: __________________________________ HOME PHONE: _______________________

CELL PHONE: ___________________________ WORK PHONE: ________________________________

FATHERS NAME: __________________________________ HOME PHONE: _______________________

CELL PHONE: ___________________________ WORK PHONE: ________________________________

EMERGENCY CONTACTS (SOMEONE OTHER THAN PARENTS, ATTEMPT WILL BE MADE TO CONTACT PARENTS FIRST)

#1 NAME________________________ NUMBER_____________________ RELATIONSHIP TO CHILD_________________

#2 NAME________________________ NUMBER_____________________ RELATIONSHIP TO CHILD__________________

DOES THIS STUDENT HAVE HEALTH INSURANCE? YES OR NO

IS THIS STUDENT COVERED BY MEDICAID YES OR NO

NOTE: If the student has no insurance and is not covered under Medicaid please ask for an MC+ form.

DOES YOUR CHILD HAVE ANY **FOOD** ALLERGIES? YES OR NO

IF YES, PLEASE LIST____

LIST THE SYMPTOMS OF YOUR CHILD'S ALLERGIC REACTION ____

ARE YOUR CHILD'S FOOD ALLERGIES LIFE THREATENING YES OR NO

NOTE: If you are requesting meal substitutions due to food allergies, you must request a form from the nurse and return it to school with a licensed physician's signature.

DOES YOUR CHILD HAVE ANY OTHER ALLERGIES? YES OR NO

IF YES, PLEASE LIST____

LIST THE SYMPTOMS OF YOUR CHILD'S ALLERGIC REACTION ____

ARE YOUR CHILD'S ALLERGIES LIFE THREATENING? YES OR NO

IF LIFE THREATENING ALLERGIES, SEE THE NURSE TO DEVELOP AN INDIVIDUALIZED HEALTH PLAN OR AN EMERGENCY ACTION PLAN.

PLEASE LIST ANY MEDICATIONS YOUR CHILD IS TAKING (PLEASE WRITE NAME OF MEDICATION, DOSAGE AND THE REASON THEY TAKE IT)

MEDICATION: ______________________ DOSAGE:_________________________ INDICATION____________________

MEDICATION: _____________________ DOSAGE:__________________________ INDICATION____________________

MEDICATION: _____________________ DOSAGE:__________________________ INDICATION____________________

IF A MEDICATION IS NEED TO BE GIVEN AT SCHOOL, PLEASE FILL OUT **MEDICATION ADMINISTRATION TO STUDENTS FORM.** (LOCATED IN THE BACK OF THE STUDENT HANDBOOK) MEDICATION MUST BE IN THEIR ORIGINAL CONTAINER WITH PRESCRIPTIOIN INFORMATION AND DOSING INFORMATION ON THE LABEL. MEDICATION SHOULD BE BROUGHT IN AND CHECKED INTO THE OFFICE BY THE PARENT/GUARDIAN.

LIST ANY RECENT/CHRONIC ILLNESS, INJURY, OPERATION OR HEALTH PROBLEM, (DIABETES, DEPRESSION, ADHD, SIEZURES ETC…) WHICH MIGHT AFFECT PERFORMANCE AT SCHOOL . PLEASE EXPLAIN.

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DOES YOUR CHILD HAVE ASTHMA YES OR NO
DOES YOUR CHILD REQUIRE A RESCUER INHALER YES OR NO

IF YES, YOU MUST FILL OUT THE **SCHOOL ASTHMA ACTION PLAN** (LOCATED IN THE BACK OF THE STUDENT HANDBOOK) AND IF THEY USE AN INHALER WE NEED THE **ADMINISTRATION OF MEDICATIONS TO A STUDENT FORM** AND/OR THE **STUDENT TO SELF-ADMINISTER MEDICATION FORM** ON FILE.

IN THE EVENT THAT YOUR CHILD HAS AN ACCIDENT OR BECOMES ILL AT SCHOOL PLEASE LIST PHYSCIAN TO BE CALLED**ALL REASONABLE EFFORT WILL BE MADE TO CONTACT YOU FIRST**

PREFERRED PHYSICIAN ________________________________ PHONE (______) ____________________

PREFERRED HOSPITAL________________________________ PHONE (______) ____________________

DENTIST____ PHONE (______) ____________________

MONTH AND YEAR OF LAST DENTAL CHECK-UP________________

EYE DOCTOR____________________________________ PHONE (______) ____________________

MONTH AND YEAR OF LAST EYE EXAM________________________

We must have parent/guardian signature at the bottom of this page before we can give any medication. Please check the appropriate blank for each medication telling us if your child may or may not have each medication. We will try to keep the following medications available at school to treat minor illnesses or injuries. You may wish to send your own medication with the appropriate form. In most cases we will be using the generic brand of these medicines.

Medication	Yes	No
Benadryl (Allergies)	Yes_____	No_____
Calamine Lotion	Yes_____	No_____
Hydrocortisone Cream	Yes_____	No_____
Eye Wash	Yes_____	No_____
Peroxide	Yes_____	No_____
Aloe Vera Gel or spray	Yes_____	No_____
Anbesol (tooth/ gum pain)	Yes_____	No_____
Triple Antibiotic Ointment	Yes_____	No_____
Tums	Yes_____	No_____
Vaseline (Chapped Lips)	Yes_____	No_____
Tylenol	Yes_____	No_____
Ibuprofen	Yes_____	No_____
Cough Drops	Yes_____	No_____
Peppermint Candy (Stomach Upset)	Yes_____	No_____
Butterscotch Candy (Sore Throat)	Yes_____	No_____

IN THE EVENT OF A LIFE THREATENING MEDICAL EMERGENCY TRAINED STAFF MAY ADMINISTER/USE: CPR, AED MACHINE, EPI PEN, AND ALBUTEROL NEBULIZER TREATMENT(S). EMS WILL ACTIVATED AND IMMEDIATE ATTEMPTS TO CONTACT PARENTS/GUARDIANS WILL BE MADE.

Authorization is given to Nodaway-Holt R-VII School Personnel to consent to medical treatment for my child, ______________________ ______________________if we, the parents/guardians are not available at the time of an injury or illness. I authorize admission to any hospital for my child if at the time of injury or illness in our absence, admission to the hospital is recommended by our private physician or a consulting physician of his/her choice. We, the parents/guardians will be responsible for the charges for any medical treatment or hospitalization rendered by reason on this authorization.

I agree to notify the school nurse of any changes in my child's health status and/or medications. I give my permission for the school nurse to communicate with all physicians or medical providers involved in my child's care regarding my child's health, medications, or diagnosis. This authorization is valid for the 2018-2019 school year.

Signature of **BOTH** legal parents/guardians

________________________________/__________ ________________________________/__________
Mother's Signature Date Father's Signature Date

One of these forms must be filled out for each child you have in school. If you would like to discuss your child's health concerns with the school call 935-2514 (Elementary) or 939-2135 (Jr. High, High School) **