Student Medical Form

HEALTH SERVICES DEPARTMENT
Waynesville R-VI School District
http://waynesville.k12.mo.us/

Please notify the nurse immediately regarding any change in the following information.

Student _____ Birth Date _____ Sex ____ Grade _____ Teacher _____

Address _____ Home Phone _____

Father's Name _____ Work Phone _____ Cell Phone _____

Mother's Name _____ Work Phone _____ Cell Phone _____

Emergency Contact _____ Phone _____

A medical authorization form must be on file in the nurse's office if medications are to be dispensed. This form must be signed by the parent for over the counter medications and signed by the parent or doctor for prescription medications before any medication can be given by the school. A new form must be presented to the school each new school year. Medications must be in the original container. Students are not allowed to transport medications except when authorized by a physician.

Prescribed Daily Medications:

Medication Name _____ Dosage _____ Time _____ Reason for this medication _____

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If a special lunch is requested, a Dietary Request form signed by the doctor and parent must be on file with the school nurse. All students will participate in regular physical education program unless a Physical Excuse Form, signed by the physician, is on record in the nurse's office at the school. For secondary age students, the individual may be placed in an Adapted Physical Education Program if he/she is unable to participate in the regular program.

For concerns, please check "yes" or "no". If yes, provide a comment explaining:

Concern	*Yes*	*No*	*Comments*	*Concern*	*Yes*	*No*	*Comments*
ADD/ADHD	☐	☐		Hearing (aids/FM device)	☐	☐	
Allergies (food, insects, latex, other)	☐	☐		Heart (no innocent murmur)	☐	☐	
Allergies (environmental, seasonal, meds)	☐	☐		Migraines	☐	☐	
Asthma (history or under treatment)	☐	☐		Neuromuscular (cerebral palsy, muscular dystrophy)	☐	☐	
Autism	☐	☐		Seizures	☐	☐	
Behavioral and/or Emotional	☐	☐		Vision (glasses/contacts/blind)	☐	☐	
Diabetes	☐	☐		Other:			

Additional information regarding your child's health: _____

Health Insurance: ☐ None ☐ Private Health Insurance ☐ Medicaid (MoHealthNet) ☐ Tricare

Check all boxes below indicating you grant permission for your child to receive the appropriate dosage for his/her age and weight of the following over the counter medications for pain, cough, sore throat, skin irritations, tooth pain, or fever of 100 degrees or above:

- ❑ Antibiotic ointment (Neosporin, Bacitracin)
- ❑ Chloroseptic Spray
- ❑ Cough drops
- ❑ Antacids
- ❑ Orajel
- ❑ Motrin or generic form per manufacturer's instructions
- ❑ Tylenol or generic form per manufacturer's instructions
- ❑ Benadryl or generic form per manufacturer's instructions

In the event of a medical emergency as determined by the school nurse or other responsible staff member, it is the policy of the Waynesville R-VI School District to dial 911 immediately to obtain emergency medical services and/or transport to the nearest approved medical facility. The parent/guardians(s) will be financially responsible for the emergency care and/or transportation for said child. As part of emergency procedures, trained school personnel may also administer, when necessary, Epinephrine (Epi-Pen) in the event of a life threatening situation. The school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.

If refused, please state in writing the action to be taken in the event of an emergency: _____

_____

Signature: _____ Date: _____