Kirksville RIII School District

Health / Emergency Form 2020-2021

Please complete and return this form with your student's enrollment information.
This form is required to be updated and on file every year.
Some questions are mandated by the State of Missouri

Student's Name: _____ Sex: M__ F__ Date of Birth: _____ Grade: ____
First M.I. Last

Mother or Legal Guardian: _____ _____ _____ _____ _____
Mother Home Phone Cell Phone Work Phone Employer

Father or Legal Guardian: _____ _____ _____ _____ _____
Father Home Phone Cell Phone Work Phone Employer

Child's Physician: _____ Phone: _____

Child's Dentist: _____ Phone: _____

Please check the type of health insurance your child has: ___ Medicaid/MO Health ___ Private Ins. ___ None
*Information regarding MO Health available upon request

Does your child wear glasses? ___ No ___ Yes **If yes**, for: ____ Distance vision ____ Near vision ____ Reading only

HEALTH/MEDICAL CONDITIONS *diagnosed by a Physician*: (ex: Asthma, Diabetes, Seizures, ADD/ADHD...)

_____
_____
_____

ALLERGIES (ex: Food, Medicine, Insect Sting, Environmental/Seasonal…) **& REACTION IF EXPOSED**

_____
_____

LIST ALL CURRENT MEDICATIONS (Include Inhalers, Epi-pen, Insulin…)

MEDICATION NAME	DOSE	ROUTE GIVEN	TIME GIVEN	HOME	SCHOOL

(*DISTRICT POLICY: If medication is deemed required at school by a physician, it must be brought in by a parent/guardian in the original, current container. *Students are NOT allowed to carry medication.* It is the responsibility of the parent/guardian to maintain an adequate supply of medication for the school.)

Please notify building nurse of any changes to this information throughout the school year.

CHECK ALL **OVER THE COUNTER** MEDICATIONS THE SCHOOL HAS PERMISSION TO GIVE YOUR CHILD:

___ Acetaminophen (Tylenol) ___ Ibuprofen (Motrin/Advil) ___ Cough Drop/Throat Lozenge ___ Antacid (TUMS)

I give permission for my child to speak with an outside mental health agency, as needed.
(e.g. Mark Twain Behavioral Health, Preferred Family HealthCare)
_____ Yes, I give my permission.
_____ No, I do not give permission.

I give permission for my child to be seen at the School Based Health Center.
_____ Yes, I give my permission. Parent will be called prior.
_____ No, I do not give permission.

Parent/Guardian Signature: _____ **Email**: _____

This copy to School Nurse