

Student's name _____

MEDICAL QUESTIONNAIRE 2010-2011**STUDENT'S NAME**

First _____ Middle _____ Last _____

Home address _____ City _____

State/Province _____ Zip Code _____ Country _____

Home phone number _____ Social Security Number _____ - _____ - _____

Height _____ Weight _____ Male _____ Female _____ Date of Birth _____

Religious preference _____ Year in school: 9th 10th 11th 12th Month/Date/Year**MOTHER or LEGAL GUARDIAN**

Name _____

Residence (If other than student's)

Home Telephone _____

Occupation _____

Employed by _____

City/State/Zip _____

Work Number _____

Cell Number _____

Fax Number _____

E-mail address _____

FATHER or LEGAL GUARDIAN

Name _____

Residence (If other than student's)

Home Telephone _____

Occupation _____

Employed by _____

City/State/Zip _____

Work Number _____

Cell Number _____

Fax Number _____

E-mail address _____

BILLING INFORMATION

The person named below is responsible for **all** medical or pharmacy expenses regarding child named at the top of the page. The Director of Health Services or Physician's office will file insurance claims if possible. **A PHOTOCOPY OF YOUR CHILD'S INSURANCE CARD IN ENGLISH MUST BE PROVIDED.** Some insurance plans are not accepted locally. If you are concerned with this please check with physicians stated in cover letter.

Name and Social Security Number of person responsible for this account:

Name _____ S.S.# _____

Address _____

Home Number _____ Work Number _____ Cell Number _____

Student's name _____

THIS PAGE MUST BE COMPLETED EACH YEAR.

EMERGENCY AUTHORIZATION 2010-2011

In the case of a medical emergency every reasonable attempt will be made to contact the parent or guardian listed above. If this is not possible a certified physician or medically trained personnel is authorized to commence any medical treatment, due to illness or accident, including initial examination, appropriate medications, and x-rays, as deemed necessary for the well-being of my child. Accompanying faculty or staff members or the Director of Health Services are authorized to sign any medical papers, or pre-operative permits for anesthesia or surgery that the hospital requires to commence medical treatment. BOTH PARENTS OR LEGAL GUARDIAN SIGNATURE REQUIRED. My child will remain in school personnel's care until released to parent or legal guardian.

XX- PARENT _____ DATE _____

XX-PARENT _____ DATE _____

In an emergency if the parent cannot be contacted the person/s named below may be given information about my child, and may take my child from school personnel's care.

Name _____ Name _____

Relation to child _____ Relation to child _____

Home phone number _____ Home phone number _____

Work phone number _____ Work phone number _____

Cell phone number _____ Cell phone number _____

HEALTH INSURANCE

Please attach a current copy of your insurance card (both sides). We must have an English card or translation of card on file. This includes primary, secondary, dental, pharmacy, etc. If parent's name is listed on insurance card, list student's name at top of the page. Any new or updated insurance cards received within the school year need to be copied (both sides) and sent to SPLHS as soon as possible.

Note: International school insurance can be purchased. Please notify the business office at your earliest convenience to purchase so there is no delay in health coverage. 660-463-2238 ext. 281.

FAMILY PHYSICIAN

I give the physician named below the authorization to speak to the Director of Health Services and/or local physician about any medical or health concern regarding my child. **BOTH PARENTS OR LEGAL GUARDIAN SIGNATURE REQUIRED.**

Family Physician _____

Address _____

Phone Number _____ Fax Number _____

LIST DAILY MEDICATIONS TAKEN BY STUDENT:

PLEASE LIST ALL ALLERGIES TO MEDICATIONS AND FOOD.

Student's name _____

**TUBERCULOSIS SCREENING 2010-2011
THIS IS A YEARLY REQUIREMENT FOR ALL STUDENTS**

Saint Paul Lutheran High School REQUIRES that your child have a YEARLY Tuberculosis screening before attending any classes.

- **A RESULT OF THE TEST MUST BE INCLUDED AND SIGNED BY THE INDIVIDUAL RESULTING THE TEST. ATTACH DOCUMENTATION.** The test must be performed after January, 2009
- International students: Even with the BCG vaccination, a TB screening (skin test) or chest x-ray must be done. Send a record of the result with this form.
- This test should be completed before school begins.

Name _____

Date & Type of TB (tuberculosis) Test _____

Date & Result of Test _____

Signature & Title of Person Reading Results of Test _____

Student's name _____

IMMUNIZATION RECORDS 2010-2011

- It is imperative that your child be in **compliance with the state of Missouri** to attend classes.
- **An updated copy of your child's original immunization records must be on file at Saint Paul Lutheran High School. If you do not have this your physician may use the chart below.**
- If your child comes to school without being properly immunized, SAINT PAUL LUTHERAN HIGH reserves the right to complete the immunization which may not be covered by insurance and can be costly.
- Note: These are common vaccines to be updated. Are there any vaccinations required before school begins? (Hepatitis B series – 3 required (may also be verified by (+) hepatitis titer); Tetanus booster – given 10 years after last DPT or Td vaccination.)
- **If there are additions, please send a new copy of the complete immunization record.**

MISSOURI IMMUNIZATION REQUIREMENTS FOR 2009-2010 ACADEMIC YEAR

GRADE	DTaP/DTP/DT/ TD**	POLIO	MEALSES	MUMPS	RUBELLA	HEPATITIS B***
6-12	3 DOSES Td booster required ten (10) years after last dose of DtaP, DTP, DT or Td.	3 DOSES Last dose on or after fourth (4 th) birthday. If a combination of IPV/OPV is received, four (4) doses are required. Maximum needed. Four (4)	2 DOSES On or after first (1 st) birthday. Twenty-eight (28) days between the two doses.	1 DOSE On or after first (1 st) birthday.	1 DOSE On or after first (1 st) birthday.	3 DOSES

**Td may be given five years after DTaP/DTP.

WE RECOMMEND THE MENINGOCOCCAL (MCV4; MPSV4) FOR ALL STUDENTS ALTHOUGH IT IS NOT A REQUIREMENT.

MEDICATION AUTHORIZATION FORM 2010-2011

If your student takes any **prescribed medication** this form **must be completed by the physician and parent and kept on file at school**. Please have pharmacist label two containers for all prescription medications, one for the Dorm Counselor and one for the Director of Health Services. The main reason for this is in case of an evacuation, the Director of Health Services will readily be able to evacuate any medication your child may need. I (parent or legal guardian) hereby request school personnel to supervise the administration of the medication for my child, named below. It is understood that the school is administering medication to my child and/or supervising the administration thereof gratuitously and in reliance on my request and the accompanying physician request. Accordingly I assume all responsibility regarding this matter and hereby release the school, its personnel and governing administrative bodies from any and all liabilities to injuries or ill effects of any kind which may be caused thereby, including those ill effects caused by school personnel failure to remind students to take the prescribed medication and to monitor its dosage.

Student's name _____ Date of Birth (Mo/Date/Yr) _____

Medication _____

Dosage/Time to be given _____ Total daily dosage _____

Starting date for medication _____ Discontinue medication on _____

Reason for taking medication _____

Possible side effects _____

XX-PHYSICIAN SIGNATURE _____ **DATE** _____

XX-PARENT SIGNATURE _____ **DATE** _____

XX-PARENT SIGNATURE _____ **DATE** _____

Additional forms available upon request or you may download through the web-site: www.splhs.org

Student's name _____

REQUEST FOR CHILD TO SELF-ADMINISTER MEDICATION 2010-2011

I have trained the child named above and consider the child to be capable of self-administering an inhaled medication, epi-pen, or insulin. *Only a rescue inhaled medication for asthma or an epi-pen for severe allergic reactions may be carried by the student.*

XX-PHYSICIAN SIGNATURE _____ **DATE** _____

In accordance with the physician's request, we want our child to self-administer the above named medication. I realize there are additional responsibilities in doing so and assume responsibility for those liabilities.

XX-PARENT SIGNATURE _____ **DATE** _____

XX-PARENT SIGNATURE _____ **DATE** _____

PARENT AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION 2010-2011

Sometimes in the course of the day when your child has a headache or not feeling well SAINT PAUL LUTHERAN HIGH has to be sure that you as a parent give us permission for your child to take the following *over-the-counter medication(s).

Note: If nothing is marked in the Over-The-Counter section, this means no medicine will be given when your child is sick. You must initial or check the medicines desired for your child.

INITIAL FOR AUTHORIZATION:

- _____ Acetaminophen(TYLENOL) – for temporary relief of aches and pains and reduces fever
- _____ Ibuprofen (MOTRIN) – for temporary relief of aches and pains and reduces fever
- _____ Tums OR Gaviscon – for heartburn and upset stomach
- _____ Bismuth(PEPTO-BISMOL) – for heartburn and upset stomach
- _____ Sinus Medication
- _____ Cough Medicine
- _____ Anti-diarrhea Medication

Other meds: _____ My child can take for discomfort as needed.

XX-PARENT SIGNATURE _____ **DATE** _____

XX-PARENT SIGNATURE _____ **DATE** _____

MEDICAL HISTORY 2010-2011

CIRCLE IF YOUR CHILD HAS EXPERIENCED:

AIDS	ALLERGIES	ASTHMA	CHRONIC BACKACHE	BRONCHITIS	CONSTIPATION
DEPRESSION	DIABETES	CHRONIC DIARRHEA	DIPHTHERIA	DIZZYNESS	EARACHE
ENURESIS	EPILEPSY	HAY FEVER	HEADACHES	HEPATITIS A B C	HIGH BLOOD PRESSURE
HIVES	HYPERACTIVITY	INDIGESTION	INFECTIOUS MONO	MALARIA	MEASLES
MENSTRUAL CRAMPS	MUMPS	NASAL CONGESTION	NERVOUSNESS	PLUERISY	PNUEMONIA
POLIO	RHUEMATIC FEVER	SCARLET FEVER	SEIZURES	SEXUALLY TRANSMITTED DISEASE	SMALLPOX
SURGERIES	TONSILLITIS	TYPHOID FEVER	TUBERCULOSIS	WHOOPING COUGH	WEAR CONTACTS/GLASSES

Please give details to any circle made. (If additional space is needed, please use the back.)

PLEASE CIRCLE IF ANY RELATIVES TO YOUR CHILD HAS EXPERIENCED THE FOLLOWING:

ASTHMA	CANCER	DIABETES	EPILEPSY
HEART DISEASE	KIDNEY DISEASE	MENTAL DISTURBANCES	TUBERCULOSIS

Please give details to any circle made above.

PARENTS STATEMENT

The Faculty and Staff at Saint Paul Lutheran High School wants to help your child reach their full potential spiritually, intellectually, morally and physically. There may be a "special need" or concern you may want to share with us so that we are able to best meet your child's needs. Please be thorough and accurate in your responses to the questions in this parents statement. Please explain in space provided. (If additional space is needed, please use the back.)

1. Is your child subject to chronic illness or any physical condition that would limit participation in school activities? Is there any health or physical problem requiring special attention?

2. Is there any current or past medical condition that an attending physician may need to know about in making the best diagnosis if your child is ill?

3. Has your child ever received counseling or assistance for emotional or behavioral issues? These may include but are not limited to the following (check all that apply):

<input type="checkbox"/> drug or alcohol use <input type="checkbox"/> depression or low self-esteem <input type="checkbox"/> self-destructive tendencies <input type="checkbox"/> confrontational behavior or problems with authority	<input type="checkbox"/> aggressive behavior <input type="checkbox"/> eating disorders <input type="checkbox"/> other (please explain) <input type="checkbox"/> none applicable
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Please fill out
this form completely.

This is very important
for your CHILD'S

HEALTH

CARE while away

from home.

Thank you.

**Note: These forms
MUST be completed
and turned in prior to*

*arriving at school or
any sport camps.*