

SPLHS DOMESTIC MEDICAL QUESTIONNAIRE 2019-2020
This form must be completed each year of attendance at Saint Paul

Date _____

STUDENT INFORMATION

Name First _____ Middle _____ Last _____

Home Address _____

City _____ State _____ Zip _____ Social Security _____

Home Phone _____ Cell Phone _____

Date Of Birth _____ School Year (circle one) 9th 10th 11th 12th

Height _____ Weight _____ Male _____ Female _____

MOTHER/LEGAL GUARDIAN

FATHER/LEGAL GUARDIAN

Name _____

Name _____

Address (if different than student)

Address (if different than student)

Home Phone _____

Home Phone _____

Cell Phone _____

Cell Phone _____

Occupation _____

Occupation _____

Employer _____

Employer _____

Address _____

Address _____

Work Phone _____

Work Phone _____

Email Address _____

Email Address _____

MEDICAL BILLING INFORMATION FOR DOMESTIC STUDENTS

The person named below is responsible for all medical, pharmacy and/or therapy expenses incurred for the above named student. The Director of Health Services or the physician's office will file insurance claims if possible. **A PHOTOCOPY OF YOUR CHILD'S INSURANCE CARD MUST BE PROVIDED.** Our local providers may not accept your insurance plan. It is your responsibility to check in advance so that you are prepared if out-of-network or non-covered items occur.

Policy Holder Name _____ Date of Birth _____

Address _____

Please return to Saint Paul Lutheran High School, P.O. Box 719, Concordia, Missouri 64020 or Fax to 660-463-7621.

EMERGENCY AUTHORIZATION FORM 2019-2020

In the case of a medical emergency, every reasonable attempt will be made to contact the parent or guardian listed below. 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 treatment. **BOTH PARENTS OR THE LEGAL GUARDIAN SIGNATURE IS REQUIRED.** My child is to remain in school personnel's care until released to parent or legal guardian.

Parent Signature _____ Date _____

Parent Signature _____ Date _____

Legal Guardian _____ Date _____

In any emergency, if a parent cannot be reached, 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 Student _____ Relation to Student _____

Home Phone _____ Home Phone _____

Work Phone _____ Work Phone _____

Cell Phone _____ Cell Phone _____

E-mail Address _____ E-mail Address _____

MEDICAL HISTORY

Please check any illness that your child has experienced.

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chronic Back Ache |
| <input type="checkbox"/> Bladder Disorders | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diphtheria |
| <input type="checkbox"/> Dizziness (vertigo) | <input type="checkbox"/> Ear Ache (chronic) | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Indigestion/Upset Stomach | <input type="checkbox"/> Infectious Mono | <input type="checkbox"/> Malaria |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Mumps | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Polio | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Sinus Issues |
| <input type="checkbox"/> Smallpox | <input type="checkbox"/> Surgeries (list below) | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Wear Contacts/Glasses | |

LIST DAILY MEDICATIONS TAKEN BY STUDENT

LIST ALL ALLERGIES TO MEDICATION AND FOOD

SURGERIES

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PARENT AUTHORIZATION FOR OVER-THE-COUNTER MEDICATIONS 2019-2020

I hereby give Saint Paul Lutheran Health Services authorization to administer the following medications for the above named student if they become ill.

Yes	No	
___	___	Acetaminophen (Tylenol) for temporary relief of aches and pains/fever
___	___	Ibuprofen (Motrin) for temporary relief of aches and pains/fever
___	___	Tums or Gaviscon for heartburn and upset stomach
___	___	Bismuth (Pepto-Bismol) for heartburn and upset stomach
___	___	Sinus Medication
___	___	Cough Medication
___	___	Anti-diarrhea Medication (Immodium)
___	___	Allergy Meds (ie: Claritin, Zyrtec)
___	___	Midol (for menstrual issues)
___	___	MEDICATIONS PRESCRIBED by child's physician _____

Parent Signature _____ Date _____

Parent Signature _____ Date _____

PARENT STATEMENT

The faculty and staff at Saint Paul want to help your child reach their full potential. There may be a "special need" or concern regarding your child that you may want to share with us so that we are able to meet those needs. Please be thorough in your responses to the questions below.

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?

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?

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

- | | | | |
|-------------------------|-----------------------------------|---|-------------------------|
| ___ Drug or alcohol use | ___ Depression or low self esteem | ___ Self-destructive Tendencies | ___ Aggressive behavior |
| ___ Eating disorders | ___ Attention Deficit Disorder | ___ Confrontational behavior or problems with authority | |

Other, please explain _____

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IMMUNIZATION RECORDS 2019-2020

- It is imperative that your child comply with the state of Missouri immunization requirements to attend classes. **Please provide an updated copy of your child's original immunization records each school year. Saint Paul is required by state law to keep these on file. If you do not have this, have your physician complete and sign the immunization chart below.**
- If your child comes to school without being properly immunized, Saint Paul Lutheran High School reserves the right to complete the immunization on your behalf, which may not be covered by your insurance, can be costly and you will be responsible for payment.
- Note: The **tetanus booster must be given 10 years after last DPT or Td vaccination**. Also, **the meningococcal vaccination (MCV4; MPSV4) is required**.

Missouri Immunization Requirement

Grade	DtaP/DTP/DT/TD	Tdap	Polio	Varicella	MMR	Hepatitis B	Meningococcal
8-12	4 Doses Td booster is required ten (10) years after last dose of DtaP, DTP, DT, or Td. Td may be given five (5) years after DtaP/DTP.	1 Dose After 8 th grade	3 Doses Last dose on or after fourth (4th) birthday, if a combination of IPV/OPV is received, four (4) doses are required. Maximum needed, four (4). IPV – 3 Doses total	2 Doses Unless had Chicken Pox	Measles, Mumps, Rubella 2 Doses On or after first (1st) birthday. Twenty-eight (28) days between the two doses.	3 Doses Required 3 doses or verified by (+) Hepatitis titer.	MCV 1 Dose 8 th grade 1 Dose 12 th grade

IMMUNIZATION RECORD

If using this form to record immunizations, please have a doctor sign or stamp that the information is correct.

Vaccine Give date each dose given	1st	2nd	3rd	4th	5th
Polio (TOPV)	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
DTaP or DTP	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Tdap	___/___/___	___/___/___	If no immunization, give month & year student had measles ___/___		
Measles (Rubeola/10day/red)	___/___/___	___/___/___	If no immunization, give month & year student had rubella ___/___		
Rubella (German, 3 day)	___/___/___	___/___/___	If no immunization, give month & year student had mumps ___/___		
Mumps	___/___/___	___/___/___			
Hepatitis A	___/___/___	___/___/___	___/___/___		
Hepatitis B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Varicella (Chicken Pox)	___/___/___	___/___/___	If no immunization, give month & year student had chicken pox ___/___		
Meningococcal (MCV4)	___/___/___	___/___/___			

Physician signature or stamp _____

If no change to the immunization record turned in previously, as a parent, please sign here. _____.

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