SPLHS DOMESTIC MEDICAL QUESTIONNAIRE 2018-2019
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

Name ____

Address (if different than student)

____

____

Home Phone ____

Cell Phone ____

Occupation ____

Employer ____

Addresss ____

Work Phone ____

Email Address ____

FATHER/LEGAL GUARDIAN

Name ____

Address (if different than student)

____

____

Home Phone ____

Cell Phone ____

Occupation ____

Employer ____

Address ____

Work Phone ____

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 2018-2019

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** ______________

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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 ______________________

MEDICAL HISTORY

Please check any illness that your child has experienced.

___ Aids	___ Allergies	___ Asthma	___ Chronic Back Ache
___ Bladder Disorders	___ Bronchitis	___ Chronic Diarrhea	___ Constipation
___ Crohn's Disease	___ Depression	___ Diabetes	___ Diphtheria
___ Dizziness (vertigo)	___ Ear Ache (chronic)	___ Epilepsy	___ Hay Fever
___ Headaches	___ Hepatitis A, B, C	___ High Blood Pressure	___ Hives
___ Hyperactivity	___ Indigestion/Upset Stomach	___ Infectious Mono	___ Malaria
___ Measles	___ Menstrual Cramps	___ Mumps	___ Nervousness
___ Pleurisy	___ Pneumonia	___ Polio	___ Rheumatic Fever
___ Scarlet Fever	___ Seizures	___ Sexually Transmitted Disease	___ Sinus Issues
___ Smallpox	___ Surgeries (list below)	___ Tonsillitis	___ Typhoid Fever
___ Tuberculosis	___ Whooping Cough	___ 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 2018-2019

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 2018-2019

- 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 8th 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** 8th grade **1 Dose** 12th 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 ____

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