

**SPLHS INTERNATIONAL 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 \_\_\_\_\_

Address \_\_\_\_\_

Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_

**FATHER/LEGAL GUARDIAN**

Name \_\_\_\_\_

Address (if different than student)  
\_\_\_\_\_  
\_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_

**HEALTH INSURANCE FOR INTERNATIONAL STUDENTS**

Medical insurance is included in your tuition/fees. Please fill out the attached 'International Insurance Coverage form and fax or mail to Saint Paul. Please contact the business office at your earliest convenience if you have any questions.

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 \_\_\_\_\_

\*\*\*\*\*

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.

- |  |  |   |  |
|--|--|---|--|
| <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

\_\_\_\_\_  
\_\_\_\_\_

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

**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 my 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	<b>4 Doses</b> 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.	<b>1 Dose</b> After 8 <sup>th</sup> grade	<b>3 Doses</b> 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	<b>2 Doses</b> Unless had Chicken Pox	<b>Measles, Mumps, Rubella</b> <b>2 Doses</b> On or after first (1st) birthday. Twenty-eight (28) days between the two doses.	<b>3 Doses</b> Required 3 doses or verified by (+) Hepatitis titer.	MCV <b>1 Dose</b> 8 <sup>th</sup> grade <b>1 Dose</b> 12 <sup>th</sup> 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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**TUBERCULOSIS SCREENING 2018-2019**  
**THIS IS A YEARLY REQUIREMENT FOR ALL INTERNATIONAL STUDENTS**

**Saint Paul Lutheran High School requires an annual negative tuberculosis screening before attending class. If test reads positive, a negative chest x-ray must accompany student for admission.**

Test results must be included and signed by the individual evaluating the test.

- Attach Documentation

Documentation of a BCG vaccination. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

- Attach Documentation

Date TB (tuberculosis) test given \_\_\_\_\_ Type of Test \_\_\_\_\_

Results: \_\_\_\_\_ Positive \_\_\_\_\_ Negative Date: \_\_\_\_\_

Please explain any positive reaction and follow-up: \_\_\_\_\_

If unable to give TB test, please give reason \_\_\_\_\_

Chest x-ray must be done if no TB test is given/or positive TB result is read \_\_\_\_\_

Signature & Title of person reading results of test \_\_\_\_\_

**INTERNATIONAL INSURANCE COVERAGE 2018-2019**

**ALL INTERNATIONAL STUDENTS ARE COVERED BY HEALTH INSURANCE. SAINT PAUL LUTHERAN HIGH SCHOOL CONTRACTS WITH INSURANCE SPECIALISTS FOR THIS HEALTH INSURANCE.**

Please provide the following information:

Student Legal Name \_\_\_\_\_

Student Birth Date (month/date/year) \_\_\_\_\_

Home Country \_\_\_\_\_

Father/Legal Guardian \_\_\_\_\_

Mother/ Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_

Agent \_\_\_\_\_

Agency Name \_\_\_\_\_

Agency Address \_\_\_\_\_

\_\_\_\_\_

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