SPLHS INTERNATIONAL 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

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 _____

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 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** _____

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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 _____

Email Address _____ Email Address _____

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 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 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 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 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 _____

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

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TUBERCULOSIS SCREENING 2019-2020
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 _____

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INTERNATIONAL INSURANCE COVERAGE 2019-2020

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 _____

_____

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