

Willow Springs R-IV School  
Student Health Information Update  
Revised 5/2009

Name \_\_\_\_\_ Grade \_\_\_\_ Boy Girl Birth date \_\_\_\_\_

Parents or Guardians \_\_\_\_\_

Doctor's name \_\_\_\_\_ Date of last check-up \_\_\_\_\_

Dentist's name \_\_\_\_\_ Date of last check-up \_\_\_\_\_

Eye doctor's name \_\_\_\_\_ Date of last check up \_\_\_\_\_

This student has:    no insurance    private health insurance    MO Health Net    Medicaid

Names and ages of other children living in your home: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child take medicine regularly?    No    Yes. If yes, please list:

Medicine name:

Taken for:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Will you be bringing medicine to school for this child?    No    Yes.    If yes, please list:

Medicine name:

Taken for:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medicine to be given at school must be brought to the Health Room by the parent or guardian. It must be in the original bottle with the full label. A medicine form must be signed for any medicine to be given at school.

{High School students may carry a small amount of plain acetaminophen which is also called Tylenol}

All other medicine must go to the Health Room.

Always leave medicine in the original bottle. Medicine that is not in the original bottle will be destroyed.

Continued on other side!

**Health Information Update**

**Page 2**

**Does your child have?**

**\*Allergies** No yes What is your child allergic to? \_\_\_\_\_

**Describe the allergic reaction:** \_\_\_\_\_

**What is done to help the student?** \_\_\_\_\_

**\*Asthma** No Yes Does your child use an inhaler? \_\_\_\_\_ How often? \_\_\_\_\_

Will your child need an inhaler at school? \_\_\_\_\_ What kind? \_\_\_\_\_

**\*Diabetes** No Yes Does your child take insulin or other medicine? \_\_\_\_\_

**\*Seizures or Epilepsy** No Yes What kind of seizure? \_\_\_\_\_

Date of last seizure: \_\_\_\_\_ Medicine: \_\_\_\_\_

**\*Heart Condition** No Yes What kind? \_\_\_\_\_

Does your child have physical limits? \_\_\_\_\_ Describe them: \_\_\_\_\_

**\*Other health problems?** No Yes What are they? \_\_\_\_\_

**Has your child had:**

A serious illness? No Yes. What kind? \_\_\_\_\_

A serious injury? No Yes. What kind? \_\_\_\_\_

Surgery? No Yes. What Kind? \_\_\_\_\_

Childhood diseases? No Yes Which ones? \_\_\_\_\_

**Does you child:**

Have trouble seeing? No Yes Wear glasses or contact lenses No Yes

Have trouble hearing? No Yes Wear a hearing aid? No Yes

**Today's Date** \_\_\_\_\_ **Signature** \_\_\_\_\_