SAINT PAUL LUTHERAN HIGH SCHOOL DOMESTIC MEDICAL QUESTIONNAIRE 2014-2015

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 _____ Social Security # _____
Address _____

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

EMERGENCY AUTHORIZATION FORM 2014-2015

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 _____ Date _____

Parent _____ 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 _____

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 _____

LIST DAILY MEDICATIONS TAKEN BY STUDENT

_____ _____
_____ _____

LIST ALL ALLERGIES TO MEDICATION AND FOOD

_____ _____
_____ _____

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SELF-ADMINISTER MEDICATION FORM 2014-2015

I consider my child capable of self-administering prescribed medication/s. The below medication/s may be carried by the student with proper physician and parent/guardian authorization. I/We realize there are additional responsibilities in doing so and assume responsibility for those liabilities.

MEDICATIONS DOSAGE REASON FOR TAKING

_____
_____
_____
_____
_____

Physician Signature _____ Date _____

Parent Signature _____ Date _____

Parent Signature _____ Date _____

MEDICATION AUTHORIZATION

If your student takes a daily prescribed medication **LONG TERM** that needs to be administered during the school day, this form **MUST BE COMPLETED BY THE PRESCRIBING PHYSICIAN AND A PARENT AND KEPT ON FILE AT SCHOOL**. The Director of Health Services will have medication readily available if your child needs it.

I (parent or legal guardian) hereby request that school personnel supervise the administration of the medication for the student named above. It is understood that the school is administering medication to my child and/or supervising that administration thereof gratuitously and in reliance per physician and my request. Accordingly, I assume all responsibility regarding this matter and hereby release the school, its personnel and governing administrative bodies from all liabilities to injuries or ill effects of any kind, which may be caused thereby, including those ill effects caused by school personnel failure to remind students to take the prescribed medication and to monitor its dosage.

MEDICATIONS DOSAGE REASON FOR TAKING POSSIBLE SIDE EFFECTS

_____
_____
_____
_____
_____

Physician Signature _____ Date _____

Parent Signature _____ Date _____

Parent Signature _____ Date _____

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PARENT AUTHORIZATION FOR OVER-THE-COUNTER (OTC) MEDICATIONS 2014-2015

I hereby give Saint Paul Lutheran High School authorization to administer the following (OTC) medications for the above named student.

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
___	___	Allergy Meds (ie: Claritin, Zyrtec)
___	___	Other medications my child is allowed to take for discomfort as needed.

_____

_____

Parent Signature _____ Date _____

Parent Signature _____ Date _____

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
___ Infectious Mono
___ Malaria
___ Measles
___ Menstrual Cramps
___ Mumps
___ Nervousness
___ Pleurisy
___ Pneumonia
___ Polio
___ Rheumatic Fever
___ Scarlet Fever
___ Seizures
___ Sexually Transmitted Disease
___ Sinus Issues
___ Smallpox
___ Surgeries
___ Tonsillitis
___ Typhoid Fever
___ Tuberculosis
___ Whooping Cough
___ Wear Contacts/Glasses

IMMUNIZATION RECORDS 2014-2015

- 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 the information using the 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 highly recommended.** However. at this time is not a requirement of Saint Paul.

Missouri Immunization Requirement

Grade	DtaP/DTP/DT/TD	Polio	Measles	Mumps	Rubella	Hepatitis B
6-12	**3 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.	**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).	**2 Doses** On or after first (1st) birthday. Twenty-eight (28) days between the two doses.	**1 Dose** On or after first (1st) birthday.	**1 Dose** On or after first (1st) birthday.	**3 Doses** Required 3 doses or verified by (+) Hepatitis titer.

IMMUNIZATION RECORD

URGENT - SAINT PAUL REQUIRES ALL IMMUNIZATIONS BE COMPLETED PRIOR TO THE STUDENT'S ARRIVAL IN THE U.S.A.

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)	____/ ____ / ____	____/ ____ / ____			

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