Student Name ____

SAINT PAUL LUTHERAN HIGH SCHOOL INTERNATIONAL MEDICAL QUESTIONNAIRE 2014-2015

Date ___________________________________

STUDENT INFORMATION

Name First __________________________________Middle ____________________________ Last _______________________________________

Home Address ____

City ____ Province ________________________________ Country ________________________________

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, P.O. Box 719, Concordia, Missouri 64020 or Fax to 660-463-7621.

Student Name ____

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

____ ____
____ ____

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

Student Name ____

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 ________________________

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

Student Name ____

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, Zertec)
___	___	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	

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

Student Name ____

TUBERCULOSIS SCREENING 2014-2015
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
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 ____

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.

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

Student Name ____

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)	____/ ____ / ____	____/ ____ / ____			

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

Student Name ____

INTERNATIONAL INSURANCE COVERAGE 2014-2015

ALL INTERNATIONAL STUDENTS ARE COVERED BY HEALTH INSURANCE. SAINT PAUL LUTHERAN HIGH SCHOOL CONTRACTS WITH CMI 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, P.O. Box 719, Concordia, Missouri 64020 or Fax to 660-463-7621.