STRAFFORD R-VI SCHOOL DISTRICT
STUDENT HEALTH INFORMATION
School Year: 2018-2019

Please Print **Grade/Teacher _____ / ________________________________**

School: *(check one)* □ **High School** □ **Middle School** □ **Elementary** □ **Early Childhood**

Student's Name ______________________________ Birth Date _______________ Sex: □**Male** □**Female**

Medical Information:

Type of Insurance: □ None □ Private □ Medicaid/MC+/Mo Health Net

Where do you take your child to seek medical care?

□ No Regular Source □ Emergency Room □ Physician/Clinic/Primary Care Provider

Doctor/Clinic: _________________________ Phone _______________ **Last Physical Exam:** ______________

Dentist: ______________________________ Phone________________ **Last Dental Exam:** ______________

Is your child under an orthodontist's care? □ Yes □ No Orthodontist Name: ________________________________

Does your child have documented proof of disease(such as chicken pox) or laboratory evidence of immunity?:

□Yes □No If yes: Date (Month/Year) _____________ Type of disease:_________________________

Does your child have a diagnosis confirmed by doctor of:

Asthma /Non-medicated	□Yes	□No	Treatment: ________________________________
Asthma/ Medicated	□Yes	□No	Medication: ________________________________
Severe Insect Allergy	□Yes	□No	Specify Insect: ________________ Treatment__________________
Food Allergies	□Yes	□No	Specify Food: _________________ Treatment___________________
Seasonal Allergies	□Yes	□No	Treatment: ________________________________
Other Allergies	□Yes	□No	Specify: ________________________________
Seizure	□Yes	□No	Date and Type :______________________________

***Must have a current action plan for asthma/food/allergy/seizure on file.

Type 1 Diabetes	□Yes	□No	Medication: ________________________________
Type 2 Diabetes	□Yes	□No	Medication: ________________________________
Migraines	□Yes	□No	Treatment: ________________________________
Heart Condition	□Yes	□No	Specify: ________________________________
Bowel/Bladder Incontinence	□Yes	□No	Specify: ________________________________
Nosebleeds (frequent)	□Yes	□No	Treatment: ________________________________
High Blood Pressure	□Yes	□No	Medication:________________________________
Hearing Problems	□Yes	□No	Hearing Aids Required: □Yes □No
Vision Problems	□Yes	□No	Glasses: □Yes □No Contacts: □Yes □No
Attention Deficit Disorder	□Yes	□No	Medication: ________________________________
Attention Deficit Hyperactivity	□Yes	□No	Medication: ________________________________
Autism	□Yes	□No	Specify: ________________________________
Behavior Disorder	□Yes	□No	Specify: _________________________ Treatment: ______________
Mental (depression, anxiety)	□Yes	□No	Specify: _________________________ Treatment: ______________
Pregnancy	□Yes	□No	Specify: ________________________________
Other	□Yes	□No	Specify: ________________________________

PLEASE DON'T FORGET THE BACK!!!

Has your child had a serious:

Illness	□**Yes**	□**No**	Specify: ______________________________
Injury	□**Yes**	□**No**	Specify: ______________________________
Surgery	□**Yes**	□**No**	Specify: ______________________________
Hospitalization	□**Yes**	□**No**	Specify: ______________________________

Does your child take medication: □ **Yes** □ **No**

Name of Medication ________________ How often: __________ For: ______________

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Does your child have a special health care need: □ **Yes** □**No** Specify: ______________

Does the special health care need require special equipment or arrangements? □ **Yes** □ **No**

Specify: ____

Does your child have a 504 plan? □ **Yes** □**No**

Additional Comments:

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□ **I give my permission for the Strafford R-VI School District to exchange medical, diagnostic, & other information, as deemed appropriate, with the student's healthcare provider &/or pharmacy.**

In case I cannot be reached, Strafford School has my permission to administer emergency treatment to my child and/or take him/her to the emergency room. I understand that the school will not be held liable in case of emergencies.

Parent Signature: ______________________ **Date:**______________

Mother's Name______________________**Phone#**______________

Mother's Work Place__________________**Phone#**______________

Father's Name______________________**Phone#**______________

Father's Work Place__________________**Phone #**______________

Name of friends or relatives we can contact if we are unable to reach mother or father:

______________________________________**Phone**______________

______________________________________**Phone**______________