

**Warsaw R-IX School District
STUDENT HEALTH INVENTORY**

Name: _____ Grade: _____ Birthdate: _____

Physicians Name: _____ Date of last exam _____ Phone Number _____

Dentist Name: _____ Date of last exam _____ Phone Number _____

Does Your Child have any of the following?

Allergies Yes ___ No ___ Allergy has required emergency action in the past? Yes ___ No ___

List drugs, food, insects, pollen and comments? _____

Asthma Yes ___ No ___ Triggered by: _____ Treatments: _____ Date Diagnosed _____

Diabetes Yes ___ No ___ Type I ___ Type II ___ Takes Insulin? Yes ___ No ___ Date Diagnosed _____

Seizures Yes ___ No ___ Date of last seizure: _____ Type of seizures _____

Does the student have any additional health or emotional concerns? Please Explain:

Does student wear glasses or contacts? Yes ___ No ___ For reading? ___ Distance? ___ Other _____

Ears: Frequent ear infections? Yes ___ No ___ Tube placement: Left ___ Right ___ Both ___

Other Ear problems/hearing difficulty: _____

List childhood diseases, serious illness, surgeries and/or injuries: _____

List any medications student is currently taking at home or at school: _____

Conditions that prevent Physical Education? (Please provide physician's note) _____

If the student requires medication at school, please obtain the appropriate forms from the school nurse. MISSOURI LAW requires schools to report immunization non-compliance. It is unlawful for any student to attend school unless properly immunized, an exempt form is on file, or student is in progress of immunizations. Parents must provide proof of immunizations. Vision, hearing and dental screenings will be done on new students, students in grades Pre-K, K, 1st, 3rd, 5th, and students who are referred by teachers, staff, or parents. All students in the district may have their height, weight and BMI's done. Students may be excused from any screening by written request from the parent. A copy of the Privacy Practices are available for your review. This notice describes how medical information about your student may be used, disclosed, and how you can get access to this information. For a copy of the Notice of Privacy Practices, please contact the school nurse and a copy will be provided.

Signature of Parent/Guardian _____ Date: _____