Student Health Inventory

Student Name	Grade	DOB	Date

Current sport physical on file at school if applicable? Yes ___ Date______________________ No ___			
Does your child have:	**Yes**	**No**	**Specify:**
Allergies			**ACTION PLAN REQUIRED YEARLY**
Asthma			**ACTION PLAN REQUIRED YEARLY**
Diabetes (Specify if on Insulin)			**CURRENT MD ORDERS REQUIRED**
Epilepsy or seizures			**ACTION PLAN REQUIRED YEARLY**
Heart condition			
Orthopedic problems			
Headaches/migraines			
Skin problems or eczema			
Trouble with close vision			
Trouble with distance vision			
Glasses or contact lenses			
Hearing difficulty			
A hearing aid			
P.E. or recess restrictions			
Nose bleeds			
Chicken Pox			Disease Y N **OR** Vaccination Y N

If your child requires the administration of prescription or non-prescription medication during school hours, complete the "Permission for Medication" form *(Appendix A)* at the beginning of each new school year or at any time your child's medication requirement should change.

If you checked "asthma" or "allergies" above, it is critical that you complete the attached *Action Plan* form at the beginning of each new school year.

If there is any critical medical information that has not been addressed on this form (e.g. student is/is not compliant with medical plan; student has reaction to medication, etc.) explain.

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Permission for Emergency Medical Care of Minors

I understand that every effort will be made to notify parents/guardians in the case of student illness or injury that requires medical attention. If I cannot be reached, or in the case of a critical emergency requiring immediate medical care, I authorize the Orchard Farm R-V School District to consent to emergency treatment for my child, ____. Authorization is also granted to the Orchard Farm R-V School District personnel to authorize admission of my child to St. Joseph Health Center in St. Charles, Missouri, if admission to the hospital is advisable by the emergency physician. Efforts, by a representative of the school district, to reach parents/guardians will continue to be made until contact is successful.

Insurance company: ____ Policy #: ___________________________________

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Parent/Guardian Signature *Date*