Hickory County R-1 School

Skyline Health Office

Phone 417-993-5851

Please fill out front and back

Student name: ____ Birth date: __________ Male/Female: ______ Grade: ______

Mother/Guardian's name: ____

Home phone: ___________________________ ___Work: ______________________ ___Cell: ___________________________

Father/Guardian's name: ____

Home Phone: _____________________ _______Work: ________________________ ___Cell: ___________________________

Parent email address: ____

Emergency contact numbers (If parents cannot be reached)

Name: ____________________________________ Number: ________________________Relationship: ___________________

Name: ____________________________________ Number: ________________________ Relationship: ___________________

My Child: (Please answer all the following questions with a Yes or No.)

May have Tylenol? ❑Yes ❑ No	May have Ibuprofen? ❑Yes ❑ No	May have Tums? (Middle School and HS only) ❑Yes ❑ No	May use Oragel? ❑Yes ❑ No	May use Liquid Band Aid? ❑Yes ❑ No
Has braces or dental appliance ❑Yes ❑ No	Has your child had a physical exam in the last year? ❑Yes ❑ No	Has your child had a dental exam in the last year? ❑Yes ❑ No	Wears glasses/or contacts ❑Yes ❑ No	May use Sunscreen? ❑Yes ❑ No
	May use Benadryl For emergencies ONLY ❑Yes ❑ No			

Health History: Please check yes or no and if yes describe

	YES	NO	Date of last occurrence	DESCRIBE
Allergies to Food/Medication				**If yes, Please fill out Allergy form in Health Office**
Allergies: seasonal				
Asthma				**If yes, Please fill out Asthma form in Health Office**
Autism				
Bone and Joint Issues/Pain				
Had Chicken Pox Date:				**If yes, according to state regulations, if your child was enrolled in Kindergarten or Pre-school in 2010 or later, you must have a signed statement from a doctor with the date disease occurred.**
Diabetes				**If yes, Please fill out Diabetes form in Health Office**
Dental Issues				
Frequent Headaches				
Frequent Stomach Issues				
Hearing or Vision Issues				
Heart Conditions/Issues				
Issues Affecting Behavior (ADHD, Depression, OCD, etc…)				
Routine Daily Medication(s)				
Cont' Daily Medications -------→				
Surgeries/Serious Accidents				
Skin Issues (ex… eczema)				
Special Diet Needed				**Signed statement from doctor must be on file in Health Office**
Seizure Disorder				**If yes, Please fill out Seizure Disorder form in Health Office**

Please continue to back →→→→→

Please list educational concerns due to health conditions/issues here.

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Dear Parents/Guardians,

The goal of our office is to provide your child a basic school health service program. This service is not meant to replace the care your child receives from your regular doctor or clinic but will provide:

- Basic emergency and first aid care (band aids, wound cleaning, injury assessment, etc)
- Administration of medications to your child with a doctor's order and your signed request. (**Note: According to Missouri State Law, students are prohibited from carrying any prescription or over the counter medications with them or on school premises. Students with asthma, anaphylaxis or any potentially life threatening respiratory illness may carry "rescue" medications with them, after demonstrating proper use in the Health Office. Parent, physician and school nurse must document permission or provide documentation of compliance)**
- Screening exams for vision, hearing, speech, dental and spinal problems. We will assist in any way possible to find medical professionals to further evaluate/correct any problem(s) discovered.
- Health information for you and your child.
- Health care plans for students with special needs, developed with students and parents.
- Maintain immunization records.
- Additional health education based on a risk assessment regarding healthy lifestyles, nutrition, personal hygiene, injury prevention and personal safety.

Our health service program is voluntary. You may withdraw permission, in writing, at any time. If you want your child to receive these services, please sign and return this form to the Health Office.

I give permission for ____ to participate in the school health program. I understand the purpose of the program and agree for my child to receive the above services EXCEPT FOR:

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By my signature below, I attest all information provided on this form to be true and accurate. I hereby give permission for Health Office staff to administer the medications I have indicated on the front of this form as needed. I agree I will update Health Office staff regarding any health or medication changes my child may experience throughout the course of the school year.

Parent/Guardian Signature: ____ Date: _________

Please list any siblings or relatives attending or working at Skyline.

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