Maryville R-II School District
Health Inventory

(Immunizations MUST be compliant with Missouri Law in order for student to attend school)

Student's Name: _____ Birthdate: _____ Grade: _____

Parent's Name: _____ Home Phone: _____ Work Phone_____

Emergency Contact if parents cannot be reached:
Name: _____ Relationship: _____ Phone: _____

Physician: _____ Dentist: _____

Medication Information- **IMPROTANT**- list medications student's takes at home or school, include inhalers.

Name of Medication & Dose	Reason for medication	Given at home or school

Health Conditions—Has a **Physician Diagnosed** your child with any of the following?

☐ Abnormal Spinal Curvature (Scoliosis)	☐ Heart Conditions
☐ Allergies/ Hayfever	☐ Hepatitis
☐ **Asthma**-# times per week inhaler used__	☐ High Blood Pressure
☐ ADD	☐ Juvenile Arthritis
☐ ADHD	☐ Kidney Disease
☐ Asperger's Syndrome	☐ Marfan Syndrome
☐ Autism	☐ Medication Allergy-List_____
☐ Bipolar Disorder	☐ Migraines
☐ Cancer	☐ MRSA (Methicillin Resistant Staph
☐ Cystic Fibrosis	☐ Mood Disorder
☐ Depression	☐ **Seizure Disorder**- Last Seizure_____
☐ **Diabetes**	☐ Speech Problems
☐ Eating Disorder	☐ **Sting Allergy**
☐ Eye problems/Poor vision	☐ Thyroid Disorder
☐ **Food Allergy (Life Threatening)**	☐ Tourette's Syndrome
☐ Gastrointestinal Disorders	☐ Other _____
☐ Hearing Difficulties	

Bolded diagnosis indicates the need of an Action Plan on file yearly- See School Nurse

What type of allergic reaction does student have to food/ insect sting and what treatment is needed?

Any health conditions not listed above or activity restrictions?

Please complete other side→

Maryville R-II School Districts has the following over-the-counter medications available to be given as needed with parent/ guardian permission. This permission is valid for the current school year. Medications will be administered per package direction and nurse discretion. Please mark over-the-counter medications your child may receive as needed at school.

- ☐ **Do NOT give my student ANY over the counter medications.**

- ☐ Tylenol (Acetaminophen) for minor pain, headache, or fever
- ☐ Ibuprofen/Advil for minor pain, fever, or inflammation
- ☐ Benadryl for mild allergic reactions or allergy (hayfever) symptoms
- ☐ Triple Antibiotic ointment for minor cuts or abrasions
- ☐ Caladryl for minor itching, rash, or bug bites
- ☐ Hydrocortisone for minor itching or rash
- ☐ Lotrimin cream for fungal rash (such as ringworm)
- ☐ Cough Drops or Robitussin DM Cough Syrup for cough
- ☐ Tums, Malanta or Maalox for minor stomach upset or heartburn
- ☐ Imodium for Diarrhea
- ☐ Anbesol or Abreva for cold sores, canker sores, or minor mouth pain
- ☐ Silvadene Burn Cream (if no allergy to Sulfa)
- ☐ Cepacol or Sucret Lozenges for sore throat
- ☐ Aloe Vera - minor sunburn

Student Name: _____ Allergies: _____

Comments:

More information can be found at the following websites:

Elementary: http://www.efes.maryville.k12.mo.us/nurses-nook.html
Middle School: http://www.mmsnurse.maryville.k12.mo.us/
High/ Technical School: http://www.mhsnurse.maryville.k12.mo.us/

I give my permission for the school nurse or health designee to administer the medications I have indicated above. I agree to notify the school nurse of any changes in my child's health status and/or medications. I authorize the school nurse to communicate to school staff interacting with my children any health concerns for my child's safety at school and/or school activities. I give permission for the school nurse to communicate with all physicians or medical providers involved in my child's care regarding any questions or concerns about my child's health, medications, or diagnosis. This information can be used for educational evaluation, health assessment and planning/ providing for health services in school or medical evaluation or treatment. This authorization is valid for the current school year.

_____ _____

Parent/ Guardian Signature Date

Please complete other side→