

Student's name \_\_\_\_\_

**MEDICAL QUESTIONNAIRE 2009-2010**

**STUDENT'S NAME**

First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_

State/Province \_\_\_\_\_ Zip Code \_\_\_\_\_ Country \_\_\_\_\_

Home phone number \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth \_\_\_\_\_

Religious preference \_\_\_\_\_ Year in school: 9<sup>th</sup> 10<sup>th</sup> 11<sup>th</sup> 12<sup>th</sup> Month/Date/Year

**MOTHER or LEGAL GUARDIAN**

**FATHER or LEGAL GUARDIAN**

Name \_\_\_\_\_

Name \_\_\_\_\_

Residence (If other than student's)  
\_\_\_\_\_

Residence (If other than student's)  
\_\_\_\_\_

Home Telephone \_\_\_\_\_

Home Telephone \_\_\_\_\_

Occupation \_\_\_\_\_

Occupation \_\_\_\_\_

Employed by \_\_\_\_\_

Employed by \_\_\_\_\_

City/State/Zip \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Work Number \_\_\_\_\_

Work Number \_\_\_\_\_

Cell Number \_\_\_\_\_

Cell Number \_\_\_\_\_

Fax Number \_\_\_\_\_

Fax Number \_\_\_\_\_

E-mail address \_\_\_\_\_

E-mail address \_\_\_\_\_

**BILLING INFORMATION**

The person named below is responsible for **all** medical or pharmacy expenses regarding child named at the top of the page. The Director of Health Services or Physician's office will file insurance claims if possible. **A PHOTOCOPY OF YOUR CHILD'S INSURANCE CARD IN ENGLISH MUST BE PROVIDED.** Some insurance plans are not accepted locally. If you are concerned with this please check with physicians stated in cover letter.

Name and Social Security Number of person responsible for this account:

Name \_\_\_\_\_ S.S.# \_\_\_\_\_

Address \_\_\_\_\_

Home Number \_\_\_\_\_ Work Number \_\_\_\_\_ Cell Number \_\_\_\_\_

Student's name \_\_\_\_\_

**THIS PAGE MUST BE COMPLETED EACH YEAR.**

**EMERGENCY AUTHORIZATION 2009-2010**

**In the case of a medical emergency every reasonable attempt will be made to contact the parent or guardian listed above. If this is not possible a certified physician or medically trained personnel is authorized to commence any medical treatment, due to illness or accident, including initial examination, appropriate medications, and x-rays, as deemed necessary for the well-being of my child. Accompanying faculty or staff members or the Director of Health Services are authorized to sign any medical papers, or pre-operative permits for anesthesia or surgery that the hospital requires to commence medical treatment. BOTH PARENTS OR LEGAL GUARDIAN SIGNATURE REQUIRED. My child will remain in school personnel's care until released to parent or legal guardian.**

XX- PARENT \_\_\_\_\_ DATE \_\_\_\_\_

XX-PARENT \_\_\_\_\_ DATE \_\_\_\_\_

**In an emergency if the parent cannot be contacted the person/s named below may be given information about my child, and may take my child from school personnel's care.**

Name \_\_\_\_\_ Name \_\_\_\_\_

Relation to child \_\_\_\_\_ Relation to child \_\_\_\_\_

Home phone number \_\_\_\_\_ Home phone number \_\_\_\_\_

Work phone number \_\_\_\_\_ Work phone number \_\_\_\_\_

Cell phone number \_\_\_\_\_ Cell phone number \_\_\_\_\_

**HEALTH INSURANCE**

**Please attach a current copy of your insurance card (both sides). We must have an English card or translation of card on file. This includes primary, secondary, dental, pharmacy, etc.** If parent's name is listed on insurance card, list student's name at top of the page. Any new or updated insurance cards received within the school year need to be copied (both sides) and sent to SPLHS as soon as possible.

Note: International school insurance can be purchased. Please notify the business office at your earliest convenience to purchase so there is no delay in health coverage. 660-463-2238 ext. 281.

**FAMILY PHYSICIAN**

I give the physician named below the authorization to speak to the Director of Health Services and/or local physician about any medical or health concern regarding my child. **BOTH PARENTS OR LEGAL GUARDIAN SIGNATURE REQUIRED.**

Family Physician \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**PLEASE LIST ALL ALLERGIES TO MEDICATIONS AND FOOD.**

\_\_\_\_\_  
\_\_\_\_\_

Student's name \_\_\_\_\_

**TUBERCULOSIS SCREENING 2009-2010  
THIS IS A YEARLY REQUIREMENT FOR ALL STUDENTS**

**Saint Paul Lutheran High School REQUIRES that your child have a YEARLY Tuberculosis screening before attending any classes.**

- **A RESULT OF THE TEST MUST BE INCLUDED AND SIGNED BY THE INDIVIDUAL RESULTING THE TEST. ATTACH DOCUMENTATION.** The test must be performed after January, 2009
- International students: Even with the BCG vaccination, a TB screening (skin test) or chest x-ray must be done. Send a record of the result with this form.
- This test should be completed before school begins.

**Name** \_\_\_\_\_

**Date & Type of TB (tuberculosis) Test** \_\_\_\_\_

**Date & Result of Test** \_\_\_\_\_

**Signature & Title of Person Reading Results of Test** \_\_\_\_\_

\_\_\_\_\_

Student's name \_\_\_\_\_

**IMMUNIZATION RECORDS 2009-2010**

- It is imperative that your child be **in compliance with the state of Missouri** to attend classes.
- **An updated copy of your child's original immunization records must be on file at Saint Paul Lutheran High School. If you do not have this your physician may use the chart below.**
- If your child comes to school without being properly immunized, SAINT PAUL LUTHERAN HIGH reserves the right to complete the immunization which may not be covered by insurance and can be costly.
- Note: These are common vaccines to be updated. Are there any vaccinations required before school begins? (Hepatitis B series – 3 required (may also be verified by (+) hepatitis titer); Tetanus booster – given 10 years after last DPT or Td vaccination.)
- **If there are additions, please send a new copy of the complete immunization record.**

**MISSOURI IMMUNIZATION REQUIREMENTS FOR 2009-2010 ACADEMIC YEAR**

GRADE	DTaP/DTP/DT/TD**	POLIO	MEALSSES	MUMPS	RUBELLA	HEPATITIS B***
<b>6-12</b>	<b>3 DOSES</b>  Td booster required ten (10) years after last dose of DtaP, DTP, DT or Td.	<b>3 DOSES</b> Last dose on or after fourth (4 <sup>th</sup> ) birthday. If a combination of IPV/OPV is received, four (4) doses are required. Maximum needed. Four (4)	<b>2 DOSES</b> On or after first (1 <sup>st</sup> ) birthday. Twenty-eight (28) days between the two doses.	<b>1 DOSE</b>  On or after first (1 <sup>st</sup> ) birthday.	<b>1 DOSE</b>  On or after first (1 <sup>st</sup> ) birthday.	<b>3 DOSES</b>

\*\*Td may be given five years after DTaP/DTP.

**WE RECOMMEND THE MENINGOCOCCAL (MCV4; MPSV4) FOR ALL STUDENTS ALTHOUGH IT IS NOT A REQUIREMENT.**

**MEDICATION AUTHORIZATION FORM 2009-2010**

If your student takes any **prescribed medication** this form **must be completed by the physician and parent and kept on file at school.** Please have pharmacist label two containers for all prescription medications, one for the Dorm Counselor and one for the Director of Health Services. The main reason for this is in case of an evacuation, the Director of Health Services will readily be able to evacuate any medication your child may need. I (parent or legal guardian) hereby request school personnel to supervise the administration of the medication for my child, named below. It is understood that the school is administering medication to my child and/or supervising the administration thereof gratuitously and in reliance on my request and the accompanying physician request. Accordingly I assume all responsibility regarding this matter and hereby release the school, its personnel and governing administrative bodies from any and all liabilities to injuries or ill effects of any kind which may be caused thereby, including those ill effects caused by school personnel failure to remind students to take the prescribed medication and to monitor its dosage.

Student's name \_\_\_\_\_ Date of Birth (Mo/Date/Yr) \_\_\_\_\_

Medication \_\_\_\_\_

Dosage/Time to be given \_\_\_\_\_ Total daily dosage \_\_\_\_\_

Starting date for medication \_\_\_\_\_ Discontinue medication on \_\_\_\_\_

Reason for taking medication \_\_\_\_\_

Possible side effects \_\_\_\_\_

**XX-PHYSICIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**XX-PARENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**XX-PARENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

Additional forms available upon request or you may download through the web-site: [www.splhs.org](http://www.splhs.org)

Student's name \_\_\_\_\_

**REQUEST FOR CHILD TO SELF-ADMINISTER MEDICATION 2009-2010**

I have trained the child named above and consider the child to be capable of self-administering an inhaled medication, epi-pen, or insulin. *Only a rescue inhaled medication for asthma or an epi-pen for severe allergic reactions may be carried by the student.*

**XX-PHYSICIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

In accordance with the physician's request, we want our child to self-administer the above named medication. I realize there are additional responsibilities in doing so and assume responsibility for those liabilities.

**XX-PARENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**XX-PARENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PARENT AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION 2009-2010**

Sometimes in the course of the day when your child has a headache or not feeling well SAINT PAUL LUTHERAN HIGH has to be sure that you as a parent give us permission for your child to take the following \*over-the-counter medication(s).

**Note: If nothing is marked in the Over-The-Counter section, this means no medicine will be given when your child is sick. You must initial or check the medicines desired for your child.**

**INITIAL FOR AUTHORIZATION:**

- \_\_\_\_\_ Acetaminophen(TYLENOL) – for temporary relief of aches and pains and reduces fever
- \_\_\_\_\_ Ibuprofen (MOTRIN) – for temporary relief of aches and pains and reduces fever
- \_\_\_\_\_ Tums OR Gaviscon – for heartburn and upset stomach
- \_\_\_\_\_ Bismuth(PEPTO-BISMOL) – for heartburn and upset stomach
- \_\_\_\_\_ Sinus Medication
- \_\_\_\_\_ Cough Medicine
- \_\_\_\_\_ Anti-diarrhea Medication

Other meds: \_\_\_\_\_ My child can take for discomfort as needed.

**XX-PARENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**XX-PARENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

## MEDICAL HISTORY 2009-2010

### CIRCLE IF YOUR CHILD HAS EXPERIENCED:

<b>AIDS</b>	<b>ALLERGIES</b>	<b>ASTHMA</b>	<b>CHRONIC BACKACHE</b>	<b>BRONCHITIS</b>	<b>CONSTIPATION</b>
<b>DEPRESSION</b>	<b>DIABETES</b>	<b>CHRONIC DIARRHEA</b>	<b>DIPHTHERIA</b>	<b>DIZZINESS</b>	<b>EARACHE</b>
<b>ENURESIS</b>	<b>EPILEPSY</b>	<b>HAY FEVER</b>	<b>HEADACHES</b>	<b>HEPATITIS A B C</b>	<b>HIGH BLOOD PRESSURE</b>
<b>HIVES</b>	<b>HYPERACTIVITY</b>	<b>INDIGESTION</b>	<b>INFECTIOUS MONO</b>	<b>MALARIA</b>	<b>MEASLES</b>
<b>MENSTRUAL CRAMPS</b>	<b>MUMPS</b>	<b>NASAL CONGESTION</b>	<b>NERVOUSNESS</b>	<b>PLUERISY</b>	<b>PNUEMONIA</b>
<b>POLIO</b>	<b>RHUEMATIC FEVER</b>	<b>SCARLET FEVER</b>	<b>SEIZURES</b>	<b>SEXUALLY TRANSMITTED DISEASE</b>	<b>SMALLPOX</b>
<b>SURGERIES</b>	<b>TONSILLITIS</b>	<b>TYPHOID FEVER</b>	<b>TUBERCULOSIS</b>	<b>WHOOPING COUGH</b>	<b>WEAR CONTACTS/GLASSES</b>

Please give details to any circle made. (If additional space is needed, please use the back.)

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### PLEASE CIRCLE IF ANY RELATIVES TO YOUR CHILD HAS EXPERIENCED THE FOLLOWING:

<b>ASTHMA</b>	<b>CANCER</b>	<b>DIABETES</b>	<b>EPILEPSY</b>
<b>HEART DISEASE</b>	<b>KIDNEY DISEASE</b>	<b>MENTAL DISTURBANCES</b>	<b>TUBERCULOSIS</b>

Please give details to any circle made above.

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## PARENTS STATEMENT

The Faculty and Staff at Saint Paul Lutheran High School wants to help your child reach their full potential spiritually, intellectually, morally and physically. There may be a "special need" or concern you may want to share with us so that we are able to best meet your child's needs. Please be thorough and accurate in your responses to the questions in this parents statement. Please explain in space provided. (If additional space is needed, please use the back.)

1. Is your child subject to chronic illness or any physical condition that would limit participation in school activities? Is there any health or physical problem requiring special attention?
2. Is there any current or past medical condition that an attending physician may need to know about in making the best diagnosis if your child is ill?
3. Has your child ever received counseling or assistance for emotional or behavioral issues? These may include but are not limited to the following (check all that apply):
 

<input type="checkbox"/> drug or alcohol use	<input type="checkbox"/> aggressive behavior
<input type="checkbox"/> depression or low self-esteem	<input type="checkbox"/> eating disorders
<input type="checkbox"/> self-destructive tendencies	<input type="checkbox"/> other (please explain)
<input type="checkbox"/> confrontational behavior or problems with authority	<input type="checkbox"/> none applicable

**PLEASE FILL OUT  
THIS FORM COMPLETELY.  
THIS IS VERY IMPORTANT  
FOR YOUR CHILD'S  
HEALTH CARE WHILE  
AWAY FROM HOME.  
THANK YOU.**