



Saint Paul Lutheran High School & Ministries

Christ-centered experiences in learning for living

Dear Parent,

The time has come to start the preparation and planning for the next school year. You and your student are getting ready to be a part of the Saints family, a Christian environment that prepares leaders to declare Christ.

Please read each medical form carefully and make sure that all information is complete and accurate. These forms will be kept on file at Saint Paul.

- These medical forms are designed to help medical personnel and/or school personnel in assisting your student in the most efficient way possible in an emergency.
- These medical forms will also be used when your child needs to be seen by a local physician.

Signatures by both parents and/or legal guardian are needed throughout these forms. We realize that for those parents of returning students this process is redundant, however it is necessary for families to review this information for accuracy and changes as well as to make us aware of any new developments.

Saint Paul Lutheran High School uses the services of the following local physicians.

Dr. Jerry Meyer, MD Meyer Medical Clinic (660-463-7966)

Dr. Dale Kesl, DO, Tanja Findley FNP Concordia Medical Clinic (660-463-4445)

Dr. Jolie Chance, DO, Deborah Koch, FNP I-70 Medical Clinic (660-463-1010)

Hospitals: Western Missouri Medical Center, Warrensburg (660-747-2500)

Lafayette Regional Hospital, Lexington (660-259-2203)

I-70 Medical Clinic, Sweet Springs (660-335-4700).

Note to parents of domestic students: If you are not sure if your insurance will cover these physicians or medical facilities, please call your insurance provider and talk this over with them.

God's Blessings!

Director of Health Services

Medical Questionnaire 2012-2013

Phone: 660-463-2238 x313 Fax: 660-463-9406 Attn: Health Services

Student Information: Date: _____

Name: First _____ Middle _____ Last _____

Home address _____ City _____ State _____ Zip _____

Home phone _____ Cell phone _____

Social Security Number ____ - ____ - ____ Date of Birth _____ School year 9th 10th 11th 12th

Height _____ Weight _____ Male _____ Female _____

Mother/Legal Guardian

Name _____

Address (if different then student)

Home phone _____

Cell phone _____

Occupation _____

Employer & Address _____

Work phone _____

Work fax _____

Email address _____

Father/Legal Guardian

Name _____

Address (if different then student)

Home phone _____

Cell phone _____

Occupation _____

Employer & Address _____

Work phone _____

Work fax _____

Email address _____

Medical Billing Information for Domestic Students Only

The person named below is responsible for all medical, pharmacy and/or therapy expenses incurred for the above named student.

The Director of Health Services or Physician's office will file insurance claims if possible. **A photocopy of your child's insurance card must be provided.** Our local providers may not accept your insurance plan. It is your responsibility to check in advance so that you are prepared if out-of-network or non-covered items occur.

Policy Holder Name _____ S.S. # _____

Address _____

Home phone _____ Work phone _____ Cell phone _____

Phone: 660-463-2238 x313
Fax: 660-463-9406 Attn: Health Services

Student Name: _____ Date: _____ Birth date ___/___/___

Emergency Authorization Form 2012-2013

In the case of a medical emergency, every reasonable attempt will be made to contact the parent or guardian listed below. 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 treatment. **BOTH PARENTS OR THE LEGAL GUARDIAN SIGNATURE REQUIRED.** My child is to remain in school personnel's care until released to parent or legal guardian.

Parent _____ Date _____

Parent _____ Date _____

Legal Guardian _____ Date _____

In an emergency: If a parent can not be reached, 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 _____ Home Phone _____

Work Phone _____ Work Phone _____

Cell Phone _____ Cell Phone _____

Health Insurance for Domestic Students

Please attach a copy of current insurance card (both sides). This includes primary and secondary insurance as well as dental and pharmacy coverage.

Health Insurance for International Students

Medical insurance is included in your tuition/fees. Please notify the business office at your earliest convenience if you have any questions.

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 THE LEGAL GUARDIAN SIGNATURE REQUIRED.**

Family Physician _____

Address _____

Phone _____ Fax Number _____

LIST DAILY MEDICATIONS TAKEN BY STUDENT:

LIST ALL ALLERGIES TO MEDICATION AND FOOD:

Students Name: _____ Date: _____

Medical History 2012-2013

Please check any illness that your child has experienced

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Ear Ache | <input type="checkbox"/> Malaria | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Enuresis | <input type="checkbox"/> Measles | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Smallpox |
| <input type="checkbox"/> Chronic Back Ache | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hives | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Polio | <input type="checkbox"/> Wear Contacts/Glasses |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Infectious Mono | <input type="checkbox"/> Scarlet Fever | |

Please initial if any relative to your child has experienced the following:

- | | | | |
|---------------------------------|-----------------------------------|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Disturbances |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |

Parent Statement

The Faculty and Staff at Saint Paul want to help your child reach their full potential. There may be a "special need" or concern regarding your child that you may want to share with us so that we are able to meet those needs. Please be thorough in your responses to the questions below.

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 (please check all that apply)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Drug or alcohol use | <input type="checkbox"/> Self-destructive tendencies | <input type="checkbox"/> Confrontational behavior or problems with authority | <input type="checkbox"/> Eating disorders |
| <input type="checkbox"/> Depression or low self esteem | | <input type="checkbox"/> Aggressive behavior | |

Other, please explain: _____

Student Name _____ Date: _____

Phone: 660-463-2238 x313

Fax: 660-463-9406 Attn: Health Services

Self-Administer Medication Form 2012-2013

I consider my child capable of self-administering an inhaled medication for asthma, an epi-pen for severe allergic reaction or insulin for diabetes. The above mentioned medications may be carried by the student with proper physician and parent/guardian authorization. I/we realize there are additional responsibilities in doing so and assume responsibility for those liabilities

Physician Signature _____ Date _____

Parent Signature _____ Date _____

Parent Signature _____ Date _____

Parent Authorization for Over-The-Counter (OTC) Medications

I hereby give Saint Paul Lutheran High School authorization to administer the following (OTC) medications for the above named student. **Please initial each medication desired for child.**

___ **Acetaminophen (Tylenol)-for temporary relief of aches and pains/fever**

___ **Ibuprofen (Motrin)-for temporary relief of aches and pains/fever**

___ **Tums or Gaviscon-for heartburn and upset stomach**

___ **Bismuth (Pepto-Bismol)-for heartburn and upset stomach**

___ **Sinus Medication**

___ **Cough Medication**

___ **Anti-diarrhea Medication**

___ **Other medications my child is allowed to take for discomfort as needed.**

Parent Signature _____ Date _____

Parent Signature _____ Date _____

Student's Name _____ Date: _____

Phone: 660-463-2238 x313 Fax: 660-463-9406 Attn: Health Services

Immunization Records 2012-2013

- It is imperative that your child comply with the state of Missouri immunization requirements to attend classes. **Please provide an updated copy of your child's original immunization records each school year. Saint Paul is required by state law to keep these on file. If you do not have this, have your physician complete the information using the chart below.**
- If your child comes to school without being properly immunized, Saint Paul Lutheran High School reserves the right to complete the immunization on your behalf, which may not be covered by your insurance, can be costly and you will be responsible for payment.

Note: The following are common vaccines required to attend Saint Paul Lutheran High School. Hepatitis B Series – 3 required (may also be verified by (+) hepatitis tier); 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

GRADE	DtaP/DTP/DT/TD**	POLIO	MEASLES	MUMPS	RUBELLA	HEPATITIS B***
6-12	3 Doses Td booster is required ten (10) years after last dose of DtaP, DTP, DT OR Td. Td may be given five (5) years after DtaP/DTP.	3 Doses Last dose on or after fourth (4 th) birthday. If a combination of IPV/OPV is received, four (4) doses are required. Maximum needed, four (4)	2 Doses On or after first (1 st) birthday. Twenty-eight (28) days between the two doses.	1 Dose On or after first (1 st) birthday.	1 Dose On or after first (1 st) birthday	3 Doses

Saint Paul recommends the meningococcal (MCV4; MPSV4) for all students, although it is not a state requirement.

Medication Authorization

If your student takes **prescribed medication** that needs to be administered during the school day, or your student is a dorm student, this form **must be completed by the prescribing physician and a parent and kept on file at school.** Please have your pharmacist label two containers for all prescription medications. One for the Dorm Counselor and one for the Director of Health Services. This is necessary in case of an evacuation. The Director of Health Services will have medication readily available if your child needs it.

I (parent or legal guardian) hereby request that school personnel supervise the administration of the medication for the student named below. It is understood that the school is administering medication to my child and/or supervising the administration thereof gratuitously and in reliance per physician and my request. Accordingly, I assume all responsibility regarding this matter and hereby release the school, its personnel and governing administrative bodies from 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 _____

Physician Signature _____ Date _____

Parent Signature _____ Date _____

Parent Signature _____ Date _____

Student's Name _____ Date: _____

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TUBERCULOSIS SCREENING 2012-2013
THIS IS A YEARLY REQUIREMENT FOR ALL INTERNATIONAL STUDENTS

Saint Paul Lutheran High School requires an annual **negative** tuberculosis screening before attending class. If test reads positive, a **negative** chest x-ray must accompany student for admission. **Meningococcal Vaccination is highly recommended however not a requirement of Saint Paul.**

- Test results must be included and signed by the individual evaluating the test.
 - Attach Documentation.
- Documentation of a BCG vaccination.
 - Attach Documentation.

Date TB (tuberculosis) test given _____ type of test _____

If unable to give TB test, please give reason _____

Chest X-Ray **must** be done if no TB test is given/or positive TB result is read _____

Signature & Title of person reading results of test _____

INTERNATIONAL INSURANCE COVERAGE

2012-2013

All international students ARE covered by health insurance. Saint Paul Lutheran High School contracts with CMI Insurance Specialists for this health insurance.

Please provide the following information:

Student Legal Name: _____

Student Birth Date (month/date/year): _____

Home Country: _____

Parents Name: _____

Date: _____

Agent and Agency Name: _____