Student Name: _____ Birth Date: _____ Gender: _____

St. Charles City School District
STUDENT HEALTH UPDATE

School: _____ Year: _____ Grade: _____

Please complete the following information which will assist us in providing your child's school health services and educational needs in a safe and effective manner.

Address: _____ Lives with: _____

Mother's Name: _____ Cell Phone: _____ Work Phone: _____

Father's Name : _____ Cell Phone: _____ Work Phone: _____

1st Emergency Contact Name/Relation: _____ Phone 1: _____ Phone 2: _____

2nd Emergency Contact Name/Relation: _____ Phone 1: _____ Phone 2: _____

ALLERGIES:

*Foods?	Y / N	Describe:
Bees?	Y / N	Describe:
Medications?	Y / N	Describe:
Animals?	Y / N	Describe:
Other?	Y / N	Describe:

MEDICAL CONDITIONS:

*Diabetes:	Y / N	Skin Condition:	Y / N
*Epilepsy/Seizures:	Y / N	Physical Handicap:	Y / N
*Asthma:	Y / N	Bleeding Disorder:	Y / N
ADD/ADHD	Y / N	Bone/Muscle Disease:	Y / N
Heart Condition:	Y / N	Frequent Headaches:	Y / N
Nose Bleeds:	Y / N	Frequent Stomach Aches:	Y / N

*Life Threatening Condition:	Y / N	Describe:
Mental Health Condition:	Y / N	Describe:
Other Health Conditions:	Y / N	Describe:

Do any of the above conditions limit/effect your child at school? Y / N

Describe:

List Surgeries:

VISION:

Concerns About Vision?	Y / N
Wears Glasses/Contacts?	Y / N
For?	Near / Far / Both
Crossed?	Y / N
Lazy Eye?	Y / N
Color Blind?	Y / N

HEARING:

Concerns About Hearing?	Y / N
Frequent Ear Infections?	Y / N
Tubes in Ears?	Y / N
Hearing Aid?	Y / N
Location?	Left / Right / Both
Cochlear Implant?	Left / Right / Both

If the child has any of the above conditions marked with '*' SEE NURSE

MEDICATIONS:

Does the student take daily medications? At Home / At School / Home & School / None

List Medications Taken Daily at Home:	List Medications Taken Daily at School:

If a student requires medication at school, please obtain the appropriate form from the nurse
Updated immunizations require signature of medical provider or clinic with day, month and year

DOCTOR / INSURANCE INFORMATION:

Doctor / Nurse Prac.?	Y / N	Name & Phone:	
Medical Insurance?	Y / N	Provider:	
Dentist?	Y / N	Name & Phone:	
Dental Insurance?	Y / N	Provider:	

Has your child had a dental exam in the last 12 months?	Y / N
Describe the condition of your child's teeth?	Y / N
Does Medicaid (MO Health Net) insure your child?	Y / N

AUTHORIZATIONS / GUARDIAN SIGNATURES:

I authorize that the information I have provided on this form is accurate to my knowledge. The information provided above will be shared as needed with school staff to provide for the health and safety of my child.

Parent/Guardian Signature:

I authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to their health.

Parent/Guardian Signature:

If I or an authorized emergency contact cannot be reached in an emergency, I authorize school staff to obtain emergency medical care as needed. I understand I will assume financial responsibility for any medical services rendered.

Parent/Guardian Signature:

Form Date: