

## 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: \_\_\_\_\_

Medications Information- **IMPORTANT**- list medications student's take at home or school, including 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?

<ul style="list-style-type: none"> <li><input type="checkbox"/> Abnormal Spinal Curvature (Scoliosis)</li> <li><input type="checkbox"/> Allergies/ Hayfever</li> <li><input type="checkbox"/> <b>Asthma</b>-# times per week inhaler used__</li> <li><input type="checkbox"/> ADD</li> <li><input type="checkbox"/> ADHD</li> <li><input type="checkbox"/> Asperger's Syndrome</li> <li><input type="checkbox"/> Autism</li> <li><input type="checkbox"/> Bipolar Disorder</li> <li><input type="checkbox"/> Cancer</li> <li><input type="checkbox"/> Cystic Fibrosis</li> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> <b>Diabetes</b></li> <li><input type="checkbox"/> Eating Disorder</li> <li><input type="checkbox"/> Eye problems/Poor vision</li> <li><input type="checkbox"/> <b>Food Allergy (Life Threatening)</b></li> <li><input type="checkbox"/> Gastrointestinal Disorders</li> <li><input type="checkbox"/> Hearing Difficulties</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Heart Conditions</li> <li><input type="checkbox"/> Hepatitis</li> <li><input type="checkbox"/> High Blood Pressure</li> <li><input type="checkbox"/> Juvenile Arthritis</li> <li><input type="checkbox"/> Kidney Disease</li> <li><input type="checkbox"/> Marfan Syndrome</li> <li><input type="checkbox"/> Medication Allergy-_____</li> <li><input type="checkbox"/> Migraines</li> <li><input type="checkbox"/> MRSA (Methicillin Resistant Staph</li> <li><input type="checkbox"/> Mood Disorder</li> <li><input type="checkbox"/> <b>Seizure Disorder</b>- Last Seizure_____</li> <li><input type="checkbox"/> Speech Problems</li> <li><input type="checkbox"/> <b>Sting Allergy</b></li> <li><input type="checkbox"/> Thyroid Disorder</li> <li><input type="checkbox"/> Tourette's Syndrome</li> <li><input type="checkbox"/> Other _____</li> </ul>
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**Bolded** diagnosis indicates the need of an Action Plan on file yearly- See School Nurse

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

Any Health conditions not listed above

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.

- **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 for minor stomach upset or heartburn
- Anbesol or Abreva for cold sores, canker sores, or minor mouth pain
- Silvadene Burn Cream (if no allergy to Sulfa)
- Aloe Vera - minor sunburn

Student Name: \_\_\_\_\_ Allergies: \_\_\_\_\_

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 interaction 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