



Health Summary Update
Mill Creek Elementary
2011-2012

COLUMBIA PUBLIC SCHOOLS

Administration Building • 1818 W. Worley Street • Columbia, MO 65203

SCHOOL _____ GRADE _____ STUDENT # _____

NAME _____ Male/Female _____ Birthdate _____
 FATHER/GUARDIAN _____ Home # _____ Work # _____ Cell # _____
 MOTHER/GUARDIAN _____ Home # _____ Work # _____ Cell # _____
 EMERGENCY CONTACT _____ / _____ / _____
 Name Relationship Phone #

TYPE OF INSURANCE _____ None _____ Employment _____ Private Self-Pay _____ Straight Medicaid (red card)
 _____ MoHealthNet _____ Which Plan? _____ Missouri Care _____ Health Care USA _____ Molina Healthcare

DOCTOR/CLINIC _____ Phone# _____ Well Child Exam in last 1yr _____ 2yr _____
 DENTIST _____ Phone# _____ Dental Exam in the last 1yr _____ 2yr _____
 PREFERRED HOSPITAL _____

MY CHILD HAS NO HEALTH CONCERNS

MY CHILD HAS THE FOLLOWING SPECIAL HEALTH CONCERNS

EYES: glasses _____ (reading/distance) _____ contacts _____ lazy eye _____ difficulty seeing _____ previous surgery _____
 Other (explain) _____

Date of last vision exam (other than school screening) _____

EARS: frequent infections _____ tubes: Right _____ Left _____ date inserted _____ hearing difficulty _____ (explain) _____
 hearing aid: Right _____ Left _____ Wear at school? Yes _____ No _____ other (explain) _____

ALLERGIES: (drugs, food, insects, pollens) Please list _____
 Has allergy required emergency action in the past? Yes _____ No _____ Describe reaction: _____

A FOOD ALLERGY SUBSTITUTE REQUIRES A PHYSICIAN'S STATEMENT OF DISABILITY

ASTHMA: _____ **** If yes, must complete Asthma History form****
 SEIZURES: _____ Describe seizure _____

Date of last seizure _____ Medication _____
 Comments _____

ATTENTION DEFICIT DISORDER (ADD/ADHD): Medications _____ Taken at: Home _____ School _____
 Comments _____

HEADACHES: _____ Describe headaches (kind and frequency) _____
 Treatment _____

DIABETES: _____ Insulin Dependent? _____ yes _____ no Physician: _____
 Describe reactions _____
 Comments _____

SICKLE CELL TRAIT: _____ yes _____ no Physician: _____ Restrictions: _____

OTHER MEDICATIONS: _____ Reason for taking _____ Taken at: Home _____ School _____

OTHER HEALTH CONCERNS: heart problem _____ bleeding _____ eating _____ sleeping _____ bowel _____ nosebleeds _____
 bladder _____ dental _____ skin _____ menstruation _____ phobias (fears) _____ blood pressure _____ lungs _____ orthopedic(bones) _____
 neurologic(brain/nervous system) _____ blood disorder _____ Explain: _____

Other illness, injury or health problems which might affect performance at school: _____
 Requires Special Nursing Health Care (specify): _____

SPECIAL EDUCATION OR SERVICES STUDENT HAS REQUIRED OR IS RECEIVING

LD _____ Speech/Language _____ EMH _____ BD _____ OT/PT _____ Counselor _____

My signature below verifies the above information to be accurate. I also permit the school nurse to share I information with school staff as deemed appropriate by the nurse, to provide for my child's health and safety.

Signature of Parent/Guardian _____ Date _____



Asthma History

COLUMBIA PUBLIC SCHOOLS
 Administration Building • 1818 W. Worley Street • Columbia, MO
 65203

Complete only if student has asthma or history of asthma.

STUDENT _____ SCHOOL _____ GRADE _____

Dear Parent/Guardian:

Please provide your child's asthma information by completing this form and returning it to the school nurse.

1. Asthma continues to be a health concern for this student? ____ Yes ____ No **If no, skip to box below.**
2. How long has this student had asthma? _____
3. What are the student's asthma triggers? _____
4. Has this student been hospitalized with asthma related problems in the last 3 years? ____ Yes ____ No
5. Has this student required urgent or emergency care due to asthma in the last 3 years? ____ Yes ____ No
6. Has this student been instructed to take daily medications to control asthma? ____ Yes ____ No
 If so, what is the medication? _____
7. Has this student used asthma medications in the last year? ____ Yes ____ No
8. Will this student be carrying his/her inhaler at school? ____ Yes ____ No **If yes, a Medication Self-Administration form must be completed and signed by the parent and healthcare provider.**
9. About how often does this student experience asthma symptoms? ____ 2 or more times per week
 ____ 2 or more times per month
 ____ 2 or more times per year
10. About how many days of school did this child miss last year due to asthma? _____
11. Physician my child sees for asthma: _____

If you answered Yes to any question 3-7, **the school must have a current asthma action plan on file.** If your physician has already developed an asthma plan, please provide a copy to the school nurse. If not, you may obtain an asthma action plan form from the school nurse for you and your child's physician to complete.

*****If your child no longer has a problem with asthma, please read the statement below carefully. Initial the box if you agree with the statement, sign below and return this packet to the school nurse. You do not need to complete any more of this packet.**

My child does not require daily medications to control asthma and has not used asthma medications in greater than 1 year. My child has not required urgent or emergency care for asthma-related problems and has not been hospitalized for asthma-related problems in greater than 3 years. Please change medical record to indicate my child has "History of Asthma."

My signature below verifies that the information I have provided on this form to be accurate.

Parent Signature and Date