

# Health Questionnaire 2009 - 2010

Student Name (use separate sheet for each student): \_\_\_\_\_

Sex: \_\_\_\_\_ Social Security # \_\_\_\_\_ Birthdate: \_\_\_\_\_ Race: \_\_\_\_\_ Grade Entering: \_\_\_\_\_

<b>Breathing Problems</b>	<b>Heart Problems</b>	<b>Neurological Problems</b>	<b>Eating Problems</b>	<b>Gland Problems</b>	<b>Orthopedic</b>
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Stomach Problems/Ulcer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Broken Bones
<input type="checkbox"/> Reactive Airway	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Dizziness, Fainting, Seizure	<input type="checkbox"/> Bowel Problems	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Orthopedic Braces
<input type="checkbox"/> Other Problem (list)	<input type="checkbox"/> Other Problem (list)	<input type="checkbox"/> ADD / ADHD	<input type="checkbox"/> Special Diet @ School	<input type="checkbox"/> Other Problem (list)	<input type="checkbox"/> Other Problem (list)

List: \_\_\_\_\_  
 Dr. Ordered Special Needs:  Glasses/Contacts  Hearing Aids  Seat close to instruction  Liberal bathroom privileges  Limited P.E.  Braces / Ortho

List your child's allergies: Food: \_\_\_\_\_

Medicine: \_\_\_\_\_

Environmental: \_\_\_\_\_

Current medications: \_\_\_\_\_ Immunizations received this year: \_\_\_\_\_ Date: \_\_\_\_\_

List prescribed medications to be given at school: \_\_\_\_\_  
*These must be given to nurse in original container.*

### MIDDLE AND HIGH SCHOOL STUDENTS ONLY: Over the counter medications

I give permission to the school nurse to give my child an age appropriate dose of the following medication when needed. DMCS will dispense up to five (5) total doses per year without a doctor's order. Cough drops and chapstick will be allowed in class. Individual teachers may refuse the privilege if misused.

Ibuprofen (Advil / Motrin)  Acetaminophen (Tylenol)

List any illnesses, operations or accidents your child had in the past year: \_\_\_\_\_

List any emotional, social or other conditions that might affect your child's school performance: \_\_\_\_\_

International Travel - My child has been outside the US during the past year (circle one): YES NO

### Emergency Information

Mother's Name (print): \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Father's Name (print): \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Physician Phone: \_\_\_\_\_ Hospital of preference: \_\_\_\_\_

Please list an additional person to contact in case of emergency (if parents cannot be reached). List a Des Moines area person only.

Emergency Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_ Phone #: \_\_\_\_\_

### EMERGENCY MEDICAL AUTHORIZATION

If your child is on routine medication or has a health condition that may require action by the nurse, you must call the nurse to set up an appointment, before the student begins attending DMCS, to discuss your child's health needs. I give permission to the school nurse to share health and emergency information with school staff on a need to know basis. Des Moines hospitals require a notarized parent signature to give emergency treatment to minors not accompanied by a parent. We have notaries on staff to aid in this process. You need only bring this form in and sign it in their presence. Every effort will be made to notify parents or others shown on the form in the event of an emergency. However, this Medical Authorization will allow treatment or care until such time as the parents can be reached. Thank you for your cooperation.

I, \_\_\_\_\_, mother/father/guardian of \_\_\_\_\_, do hereby give my permission and/or consent to Des Moines Christian School to secure and authorize such emergency medical care and/or treatment as my child (above named) might require while under the supervision of Des Moines Christian School. I also agree to pay all costs and fees contingent on any emergency medical care and/or treatment for my child as secured or authorized under this consent. I agree to this authorization for the time during the school year 2009-2010 that my child attends Des Moines Christian School and will inform the school as to any change in the name of the medical provider, hospital, or my child's medical condition.

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### TO BE COMPLETED BY NOTARY PUBLIC

Stamp/Seal: \_\_\_\_\_

Subscribed and sworn to before me by the said \_\_\_\_\_

This \_\_\_\_\_ Day of \_\_\_\_\_, 20\_\_\_\_\_

Notary Public in and for the State of Iowa \_\_\_\_\_ Date Commission expires: \_\_\_\_\_