Annual Student Health Information Form
Special School District of St. Louis County

STUDENT INFORMATION

Student ID#: _____

Student Name: _____ Date of Birth: _____

Educational Decision Maker 1: _____ Phone Number: _____

Educational Decision Maker 2: _____ Phone Number: _____

Alternative Contact Name: _____ Phone Number: _____

HEALTH PROFESSIONAL INFORMATION

☐ I give consent for SSD nursing staff to contact my child's health care providers:

_____
(Parent/Guardian Signature)

Primary Care Provider: _____ Phone Number: _____

If your child has more than one physician, please fill out the eForm for additional physicians.

Dentist: _____ Phone Number: _____

Specialist: _____ Phone Number: _____

Preferred Hospital: _____

NOTICE OF AGREEMENT

☐ To ensure safe care of my child, I agree that pertinent health information may be shared with appropriate school staff on a need to know basis. I agree to alert the school nurse of any change in medication or health status of my child. I will furnish the school with current phone numbers and addresses in case of emergency. Each school building is stocked with Epinephrine (Epi-Pen) and Albuterol to be administered in case of an emergency. I understand that basic first aid and emergency care will be provided when needed.

☐ I understand that in an emergency my child will be transported by an ambulance. I authorize emergency personnel to carry out diagnostic and emergency care as deemed necessary. I understand the cost of ambulance and medical care is my responsibility.

☐ I acknowledge that the foregoing below information is true and correct.

_____
(Parent/Guardian Signature)

SPECIAL SCHOOL DISTRICT OF ST. LOUIS COUNTY

Annual Student Health Information Form
Special School District of St. Louis County

Student Name: _____

HISTORY/MEDICAL DIAGNOSES

History of Allergies: ☐ Yes ☐ No
Drug Allergies: ☐ Yes ☐ No
Food Allergies: ☐ Yes ☐ No
Insect Allergies: ☐ Yes ☐ No
Other Allergies: ☐ Yes ☐ No
If yes to any of the above, please list:

Does your student have an Epi-Pen?: ☐ Yes ☐ No

Asthma: ☐ Yes ☐ No
Use of Rescue or Emergency Medication: ☐ Yes ☐ No
Please list any emergency medication:

Diabetes: ☐ Yes ☐ No
Type I ☐ Type II ☐

Emotional/Behavioral Health: ☐ Yes ☐ No
If yes, please specify:

Nutritional Needs: ☐ Yes ☐ No
Dietary Modifications: ☐ Yes ☐ No
Safe Eating Plan: ☐ Yes ☐ No
Puree: ☐ Yes ☐ No Ground: ☐ Yes ☐ No
If yes, please specify:

Seizure Disorder: ☐ Yes ☐ No

ADD: ☐ Yes ☐ No
ADHD: ☐ Yes ☐ No
Autism: ☐ Yes ☐ No
Genetic Disorder: ☐ Yes ☐ No
Glasses/Contacts: ☐ Yes ☐ No

Heart/Lung: ☐ Yes ☐ No
Hearing Concerns: ☐ Yes ☐ No
Hearing Aide: ☐ Yes ☐ No
Mobility Concerns: ☐ Yes ☐ No

If yes to any of the above, please specify

Student Name: _____

Does your child receive prescription medication(s) at home?: ☐ Yes ☐ No
If yes, please list medications here, including the **dose**, **frequency,** and **reason**:

Does your child require medication during the school day?: ☐ Yes ☐ No
If yes, please complete the Request for Administration of Medications at School form, which can be accessed on the Nurses' page of our schools website and return with the medications to the school's office.

Other health concerns/comments/nursing care requested at school (e.g., g-tube, orthopedic devices):

ADDITIONAL FORMS NEEDED

Additional forms need to be completed and submitted to the school's health office. These forms include:

- ☐ Request for Over-the-Counter Medication for Students
- ☐ Immunization Records
- ☐ Physical Examination (Firefighting, EMT, or Health Science Tech programs only)
- ☐ Nurse Practitioner Clinic Permission Form
- ☐ Seizure Action Plan and Parent Questionnaire, if answered yes to Seizure Disorder
- ☐ Diabetes Action Plan (if answered yes to Diabetes above)
- ☐ Asthma Action Plan (if answered yes to Asthma above)
- ☐ Allergy Action Plan (if answered yes to Allergies above)

The above forms can be found via the Student Health webpage: www.ssdmo.org/HealthServices.