



Blue Springs School District Clinic Information Sheet

Student Information:

Student: _____ D.O.B. _____ Gender: _____ School Year: _____

Parent/Guardian: Mother: _____ Father: _____

Step-Mother: _____ Step-Father: _____

Guardian/Other: _____

Health Information:

List any health/emotional conditions that have been **medically diagnosed**, and if they will affect your child during the school day: _____

Does your child have any known allergies? YES NO

If yes, please list allergy: _____

Has your Health Care Provider informed you that your child's allergy is life threatening? YES NO

Will you provide emergency medication for your child at school in case of an allergy exposure? YES NO

Insurance Information:

Is your child covered under? Private Insurance Medicaid/Missouri Health Net None

Has your child had a doctor's exam in the last 2 years? YES NO Physician: _____

Does your child have dental insurance? YES NO

Has your child had a dental exam in the last 12 months? YES NO Dentist: _____

Medications:

All prescription medications must be delivered to the school health clinic personnel by a parent, legal guardian, or designated adult.

All over-the-counter medications that are kept in the school clinic require a physician's order.

Secondary Students (grades 6-12) may self administer over-the-counter medications provided the student carries a current written authorization from the parent/legal guardian which gives permission for the specific medication to be self-administered and the student carries no more than one day's supply of the over the counter medication in their possession in the original container.

**Please note that if these guidelines are not followed, the student may face disciplinary action. Please see District Policy #5.97 for further information.*

IN AN EXTREME EMERGENCY, YOUR CHILD WILL BE TRANSPORTED TO THE NEAREST EMERGENCY ROOM.

It is the responsibility of the parent/guardian to update health information on a YEARLY basis, or as needed. Parent signature indicates the above information is complete and accurate.

Parent/Guardian Signature: _____ Date: _____

**Thank You,
Health Services**