

**WHEATON R-III SCHOOL DISTRICT
HEALTH INVENTORY**

PLEASE COMPLETE BOTH SIDES OF THIS FORM.

All information is confidential and will be kept in your child's permanent health record. If this information changes, please contact your child's school nurse.

Pupil's name _____ Grade _____

Date of birth _____ Sex: M F

Pupil's home address _____

Name of person(s) with whom child lives _____

Parent/Guardian (#1) _____

Address _____ Home phone _____

Place of employment _____ Work phone _____

Cell phone _____

Parent/Guardian (#2) _____

Address _____ Home phone _____

Place of employment _____ Work phone _____

Cell phone _____

Names and grades of brothers and sisters _____

Please list three persons with transportation to be contacted if parents cannot be reached in case of illness or emergency:

Name _____ Relationship to child _____

Address _____ Phone _____

Name _____ Relationship to child _____

Address _____ Phone _____

Name _____ Relationship to child _____

Address _____ Phone _____

Student Health Information

Allergies _____

Does your child take any regular medication? Yes _____ No _____

If yes, please list medication, time it is taken, and what it is taken for: _____

Any **health information** or **medical diagnosis** the school nurse should know: _____

Does your child use any special device/equipment?

Please list: _____

Does your child wear glasses or contact lenses? _____

Does your child have health insurance? Yes _____ No _____

Does your child have Medicaid/MO HealthNet? Yes _____ No _____

Physician's name _____ Phone _____

IN CASE OF A SERIOUS EMERGENCY, WITH PARENTS UNAVAILABLE, YOUR CHILD WILL BE TRANSPORTED BY AMBULANCE TO A HOSPITAL.

YOUR HOSPITAL CHOICE: _____

I give permission for the following medications to be given to my child at school as outlined in the standing medication orders of the Wheaton School District. (Medication cannot be administered to preschool students)

Tylenol Yes ___ No ___ Ibuprofen (ages 12 and up only) Yes ___ No ___ Antacid Yes ___ No ___

Cough Drop Yes ___ No ___ Burn gel for minor burns Yes ___ No ___ Anti-itch ointment for itching and minor skin irritations Yes ___ No ___ Antibiotic ointment Yes ___ No ___

Parent/Guardian Signature: _____

Date: _____