Notre Dame de Sion School

MS Student Health History

ndsion.edu

GRADE SCHOOL | 3823 Locust Street | Kansas City, MO 64109 | 816.753.3810
HIGH SCHOOL | 10631 Wornall Road | Kansas City, MO 64114 | 816.942.3282

STUDENT INFORMATION

Student Name: _____ Gender: male female

Date of Birth: _____ Grade: 6 7 8

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Preferred Hospital: _____

Emergency Contact: _____ Phone: _____

Health Conditions (check those that apply)					
ADD/ADHD		Cardiovascular (Heart/Blood Disease)		Seizures	
Allergies/Anaphylaxis		Diabetes		Visually Impaired	
Asthma		Eating Disorder		Hearing Impaired	
Behavioral/Emotional/Psychological		G.I. Disorder (Stomach/Intestinal)		Migraine Headaches	

Please fully explain any answers checked above (include severity of symptoms of any allergies)

_____

_____

Please list any medication the students takes on a regular basis

_____

Please list any physical education restrictions if applicable

_____

Please list any other factors that the school, counselor, or your child's teacher(s) should know that might affect the student's school experience

_____

I authorize school personnel to obtain emergency medical care for my child in the event I cannot be reached. If transportation by ambulance is required, this may be obtained.

_____ _____

Parent/Guardian Signature Date

I authorize school personnel to administer over the counter medications.

_____ _____

Parent/Guardian Signature Date

Please initial one below:

_____This health information is confidential and is not to be shared with anyone outside the health room unless needed for emergency reasons.

_____I feel it is important to share health information with the teaching staff as appropriate.

PHYSICAL EXAMINATION

To be completed by health care provider approved to perform health assessments

height		vision (R and L)	
weight		contacts or glasses	
blood pressure		* females only	
pulse		date of last menstrual period	

response codes 0 = no significant findings 1 = significant findings								
	code	description of findings		code	description of findings		code	description of findings
general appearance			oral/dental			abdomen		
integument			thorax			musculoskeletal		
head - neck			breasts			genitourinary		
EENT			cardiovascular			neurological		

Significant assessment findings: _____
_____
_____

The above named individual has been cleared for participation in the following sports			
contact collision (football, soccer, wrestling, etc.)		non-contact moderately strenuous (badminton, table tennis, etc.)	
limited contact (baseball, basketball, volleyball, etc.)		non-contact non-strenuous (golf, archery, etc.)	
non-contact strenuous (track, field, running, tennis, etc.)		other:	

ATTACH AN IMMUNIZATION RECORD TO THIS FORM

Physician's Signature: _____ Date: _____