Notre Dame de Sion School

GS New 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: M K 1 2 3 4 5 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.

complete both sides of the Student Health History Form

PHYSICAL EXAMINATION

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

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

Significant assessment findings: _____
_____

MEDICAL HISTORY (please check all that apply)					
chicken pox		menstrual		ADD/ADHD	
musculoskeletal		gastrointestinal		hearing	
allergies/anaphylaxis		cardiovascular		emotional	
migraines		seizures		asthma	
fractures		urinary		other	

Immunization Record								
	DPT, DT, DTaP, or Tdap	Hib	OPV or IPV	Hep B	MMR	Varicella	PCV or Prevnar	Hep A
dose #1								
dose #2								
dose #3								
dose #4								
dose #5								
dose #6								

All immunizations must be current by the first day of school for the student to be admitted.
Please indicate above the dates of your child's immunizations.

Physician's Signature: _____ Date: _____