MICDS

GRADE JK-6 HEALTH FORM PACKET

January 31, 2018

Dear MICDS Parent of a JK-6th grader,

Due to upcoming changes to our online form system on the MICDS portal, we are moving to a paper health form packet for this year only. Attached to this letter are the health forms for students in grades JK-6 for the 2018-2019 school year. Please note that not all pages need to be completed for every student. Below is a checklist that will help you identify which pages are required for your child. All pages are numbered at the bottom of the page.

Please print the attached forms and complete all of the required forms for your child's grade level. Please contact your doctor immediately to make an appointment since these are due by June 29, 2018.

	REQUIRED FORMS FOR MY CHILD IF S/HE IS:		
Page #/Form	New student JK-6	Returning SK	Returning 1st-6th
Immunization Record (received from your doctor)	Yes	Please submit if your child has received a new immunization within the past year.	Please submit if your child has received a new immunization within the past year.
Page 1 – Emergency Information	Yes	Yes	Yes
Page 3 – Updated Medical History	Yes	Yes	Yes
Page 4 - Physical	Yes	Yes	n/a
Page 5 – Medication Authorization Form	To be completed at least once a school year for any medication that will be administered during the school day, including over the counter medications.		

If your child has a medical condition (such as asthma, diabetes, allergies etc.), please share specific health plans from the treating medical professional. If your child has medication to be given during school hours, please have your physician complete Page 6, include your signature, and turn this form in with the other health forms.

If your child's physical is scheduled for after June 29, 2018, but before the first day of school, please turn in all of the other completed forms before the deadline and then turn in the physical as soon as it is completed. If you cannot get a physical appointment before the first day of school, please contact Lise Olson for advice/assistance.

Please note, if any part of the form is incomplete due to missing/invalid information or signatures, the form will be returned to you for completion. No student will be allowed to enter school or participate in athletics without these forms filled out properly.

Please complete and return these forms, including the physical exam, by June 29th, 2018.
Please mail, email, or fax the form to

Lise Olson, LS/MS Nurse

101 N. Warson Road
St. Louis, MO 63124
lolson@micds.org

Phone 314-995-7437
FAX 314-995-7421

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2018-2019 Medical Information Form – Grades JK-12

Grades *JK-8* mail to: *LS/MS Nurse*, 101 N. Warson Rd - St. Louis, MO 63124 (Fax 314-995-7421)
Grades *9-12* mail to: *Stacey Morgan*, 101 N. Warson Rd - St. Louis, MO 63124 (Fax 314-995-7456)

I. Emergency Information: _____

Student's Name_____ Home Phone_____

Primary Address_____ City_____ Zip_____

Parent Email Address(es):_____

Sex_____ Age_____ Date of Birth_____ Grade entering _____ **New Student? Yes* No**
(circle one)

Mother_____ Daytime Phone_____ Cell Phone_____

Father_____ Daytime Phone_____ Cell Phone_____

Emergency Contact_____ Relationship_____ Phone_____

Current Physician_____ Phone _____

Other Medical Specialist_____ Phone _____

Medical Conditions (e.g.,Allergies,diabetes,asthma)_____

II. Authorizations: _____

A1. **Medical Consent:** In the event my child needs emergency medical treatment and none of the individuals named above can be reached, I give my consent to MICDS to obtain -through a licensed medical professional and hospital of choice- such medical care as is reasonably necessary for the welfare of my child. I also agree to assume the cost for transport and medical treatment in such an emergency situation.
DO YOU HAVE A PREFERRED TREATMENT FACILITY? (Specify)_____

A2: **Immunizations:** I have provided MICDS with my child's immunization records, and any updates thereto, as required by RSMo §167.181

Signature of Parent/Guardian: X_____ Date:_____

B. **Medication:** : (Dosages will be determined by weight/age unless otherwise specified)
Acetaminophen (*Tylenol*) ☐Yes ☐No **Ibuprofen** (*Advil, Motrin*) ☐Yes ☐No **Calcium Carbonate** (*Tums*) ☐Yes ☐No
Signature of Parent/Guardian: X_____ Date:_____

C. **Health/Accident Insurance -** All students in grades 7-12 must have health/accident insurance to attend school.
My child is covered by basic health/accident insurance and the information is provided below.

Company:_____

Subscriber:_____ Policy/Group Number:_____

D. **Parent Permission:** I hereby consent for the above student to represent the school in interscholastic athletics. I also give consent for my child to accompany the team on trips and will not hold the school responsible in case of accident or injury whether it is in route to or from another school, during practice, or an interscholastic contest.

Signature of Parent/Guardian: X_____ Date:_____

MICDS's Health Services, in collaboration with the school's consulting physician, have agreed to the administration of certain over-the-counter (OTC) medications according to the physician's standing order. Listed below are the OTC medications that, based on professional nursing assessment and judgment, may be administered to students who have parental permission (see signature below). Our goal is to minimize both absenteeism and student discomfort while in the school setting and to maximize instructional time. Dosing of medication will be according to the package labeling based on age/weight and indications. Some medications are listed by brand names to assist in recognition of the medication, although a comparable brand or generic equivalent may be stocked.

The nurse may delegate and thereby will supervise the administration of medication by unlicensed personnel who are qualifies by education, knowledge, and skill to administer medication.

The school nurse is not obligated to dispense medications where, in his/her judgment, such use would not be appropriate despite the above mentioned indications.

Oral Medications	Topical Medications
Tylenol (acetaminophen) for minor pain, fever reduction	Caladryl (pramoxine)/Calamine for rashes, itching
Advil/Motrin (ibuprofen) for minor pain, fever reduction	Hydrocortisone 1% cream for rashes, itching
Benadryl (diphenhydramine) for hives, itching	Benadryl (diphenhydramine HCL) cream for rashes, uncomplicated bee stings
Tums (calcium carbonate) for indigestion, upset stomach	Solarcaine (lidocaine), Mediquick, Foille ointment for minor burns
Throat lozenge for cough or sore throat	Water Burn Gel for minor burns
Eye Medications	A&D ointment, for skin irritation, minor burns
Eye wash solution (daricose solution, callyrium) for irrigation, rinsing of eyes	Chloraseptic (phenol) spray or gargle for sore throat
Eye drops for dry eyes (saline solutions, artificial tears)	Vaseline for dry chapped skin and lips,sites of friction without erosion
Multi-purpose solution for contact lens care	Sting Kill Swabs, topical anesthetic for insect bites & stings
Antihistamine drops for itchy eyes (Visine A or equivalent)	Bactine, Unguentine, first aid cleansing for abrasions
Visine, Murine, Clear Eyes for minor conjunctiva irritation	Camphophenique/Blistex, medicated lip ointment
	Mineral Ice, Ben Gay, & muscle balm, for muscle aches
	Mouthwash for mouth refreshment & mouth care
	QR powder for bleeding not stopped with pressure
	Liquid Band Aid, for open wounds difficult to dress with bandage
	Anbesol/Orajel, for oral lesions (e.g.,canker sores)

III. MEDICAL HISTORY -

Today's Date:	
Student Name:	Division: (circle one) LS MS US

Medicines: Please list all of the prescription and over-the –counter medications and supplements (herbal & nutritional) that you are currently taking:

Allergies: Yes □ No □ If yes, please identify specific allergy below:
□ Medicines: □ Pollens: □ Food: □ Stinging Insects:
Has the student experienced an anaphylactic reaction to the allergen? Yes □ No □

Explain "YES" answers below. Circle questions you do not know the answer to:

General Questions	Yes	No	Medical questions	Yes	No
1.Has a doctor ever denied or restricted the student from participation in sports for any reason?			21. Does the student regularly use a brace, orthotics, or other assistive device?		
2. Does the student have any ongoing medical conditions? If so, please check: □ Asthma □Anemia □Diabetes If yes, complete physician authorization form			22. Does the student have a current injury?		
			23. Do any of their joints become painful or swollen?		
3. Has the student ever spent the night in the hospital?			24. Does the student have a history of juvenile arthritis or connective tissue disease?		
4. Has the student ever had surgery?					
Heart Health Questions About The STUDENT	**Yes**	**No**	25. Does the student cough, wheeze or have difficulty breathing during or after exercise?		
5. Has the student ever passed out or nearly passed out DURING or AFTER exercise?			26. Has the student ever used an inhaler or taken asthma medication?		
6. Has the student ever had discomfort, pain, tightness or pressure in your chest during exercise?			27. Does anyone in your family have asthma?		
			28. Has the student had a hernia in the groin area?		
7. Does the student's heart ever race or skip beats (irregular beats) during exercise?			29. Does the student have a history of seizure disorder?		
8. Has a doctor ever told the student that they have any heart problems? If so, check all that apply: □ High blood pressure □High cholesterol □ A heart murmur □ Other:			30. Has the student had infectious mononucleosis within the last month?		
			31. Doe the student have rashes, pressure sores or other skin problems?		
9. Has a doctor ever ordered a test for the heart of this student? (ECG, EKG, echocardiogram)			32. Has the student had a herpes or MRSA skin infection?		
10. Does the student get lightheaded or feel more short of breath than expected during exercise?			33. Was the student born without or are you missing a kidney, an eye, a testicle (males) or spleen, or any other organ? If yes, specify:		
11. Has the student ever had an unexplained seizure?			34. Has the student ever had a head injury or a concussion? Specify date(s):		
12. Does the student get more tired or short of breath more quickly than their friends during exercise?			35. Has the student ever had a hit or blow to the head that caused confusion, headaches or memory problems?		
Heart Health Questions About the FAMILY	**YES**	**NO**	36. Does the student have headaches with exercise?		
13. Has any family member or relative died of heart related problems or had an unexplained or unexpected sudden death before age 50?			37. Has the student ever had numbness, tingling or weakness in his/her arms or legs after being hit or falling?		
			38. Has the student become ill exercising in the heat?		
14. Does anyone in your family have a heart problem, pace maker, or implanted defibrillator?			39. Does the student get cramping while exercising?		
15. Has anyone in your family had unexplained fainting, seizures or near drowning?			40. Does the student or a family member have sickle cell trait or disease?		
Bone and Joint Questions	**YES**	**NO**	41. Has the student had any problems with his/her eyes or vision? Or had an eye injury?		
16. Has the student ever had an injury to a bone, muscle, ligament, tendon that caused you to miss a practice or game?			42. Circle one if student wears: Contacts or Glasses		
			43. Has the student ever had an eating disorder?		
17. Has the student ever had a broken/ dislocated bone?			**Explain YES answers here or on the back of this page:**		
18. Has the student ever had a stress fracture?					
19. Has the student ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, cast or crutches?					
20. Has the student had an x-ray for neck instability?					

I hereby state that, to the best of my knowledge, my answers to the above are complete and correct.

Signature of Parent or guardian:	Date:

IV. PHYSICAL EXAMINATION - To be completed by physician

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Name:	Date of Birth

EXAMINATION

Height:	Weight:	☐ Male	☐ Female
BP: /	Pulse:	Vision: R 20/ L 20/	Corrected: ☐ Yes ☐ No

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/Ears/Nose/Throat • Pupils equal • Hearing		
Lymph Nodes		
Heart • Murmurs(auscultation standing, supine, +/- valsalva • Location of point of maximal pulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm/wrist/hand		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck walk, single leg hop		

IMMUNIZATIONS: ALL NEW STUDENTS MUST SUBMIT AN IMMUNIZATION RECORD W/ MEDICAL FORMS

RETURNING STUDENTS: **Need ONLY to submit a record of any RECENT immunizations**

☐ Cleared for all sports without restrictions ☐ Cleared for full participation in Physical Education

☐ Cleared for all sports and Physical Education with the following restrictions:
Specify:

☐ Not cleared: ☐ Pending further evaluation ☐ for any sport/PE ☐ For specific sports: (list)

I have examined the above-named student and completed the pre-participation physical examination. The student does not present apparent clinical contradictions to practice and participate in sports/physical education as outlined above.

Name of Physician: (print)	Date:
Address:	Phone:
Signature of Physician:	

MICDS Authorization For Administration of Medication*

Please complete every item on this form.

STUDENT'S NAME: _____

Physician's Order

I have examined this student for (diagnosis): _____
and have determined she/he requires medication during school hours.

*MICDS upper and middle school students may have an Epi-pen, Insulin, Glucagon, or an inhaler in their possession, if the following authorization form is on file in the nurse's office. *PLEASE NOTE: all other medications must be kept in the nurse's office, respectively.*

- ❑ This student **should not** carry his/her medication by him/herself.
- ❑ The student **should** be allowed to carry and use medication by him/herself.

Name of Medication: _____ Dosage: _____

Name of Medication: _____ Dosage: _____

Directions for Administering Medication: _____

_____

_____

_____

_____

Administration period of above medication(s) (actual dates): From: _____ To: _____

Contact me if the following signs or symptoms appear: _____

_____

_____

Physician Signature: X _____ **Date:** _____

Printed Name: _____ **Phone:** _____

Parent/Guardian Statement

I/We, the undersigned parent(s)/guardian(s) of _____
Request that the MICDS nurse or her designee administer the above named medication to this student according to the physician's instruction. I/We agree to furnish the necessary prescribed medication in a labeled pharmacy container and agree to notify the school nurse immediately if the physician or medication prescription is changed. The medication will remain at the school for the duration of the administration period.

Parent/Guardian Signature: X _____

Home Phone: _____