Dora R-III School District
2017-2018
Enrollment Form/Student Health Inventory
Please fill out forms completely…

Name _____Boy____ Girl____ Age_____ Birth date _____Grade_____
(Last) (First) (Middle)

Address _____City_____ Zip _____

Resident ☐ Non-Resident ☐ **County**: Ozark ☐ Douglas ☐ Howell ☐
Insurance Provider _____ Medicaid Yes_____ No _____ Medicaid # _____

Are parents of this student divorced? yes ☐ no ☐ If so, who has custody? _____
****Please furnish a copy of the custody papers to the school****

Parent/Legal Guardian(s) _____Home Phone_____

Please list all other children in your family:

_____Age_____ _____Age____

_____Age_____ _____Age____

Parents Contact Info: Father's name: _____ Mother's name: _____
Employment: _____ Employment: _____
Work Phone: _____ Work Phone: _____
E-mail address: _____ E-mail address: _____
Cell Phone: _____ Cell Phone: _____

*****Emergency Contacts:*** **Please put in the order you would like them contacted. (PARENTS will be contacted first)**

#1 Name: _____ **#2** Name: _____
Phone: _____ Phone: _____
Relationship: _____ Relationship: _____

Name of Last School attended_____City_____ State_____

Doctor's Name _____ Date of last visit _____ Phone # _____

Dentist's Name _____ Date of last exam _____ Phone # _____

Is your child under an orthodontist's care No ____Yes _____ Doctor's Name _____ Phone # _____

If your child is hurt or ill, where would you take him/her? (ie, ER, Urgent Care, Doctor office name) _____

Does this student attend any of these special classes? L.D. ☐ E.M.H ☐ B.D. ☐ Remedial ☐ Gifted ☐ Speech ☐

During the past 3 years, has either the parent or guardian, or the student, or the student's spouse, been employed (or are any of the aforementioned persons currently employed) in some form of temporary or seasonal agricultural or agricultural related work such as; (check all that apply)

____ Planting, harvesting, or processing crops (vegetables, fruit, cotton, etc.)
____ Transporting farm products to market
____ Feeding or processing poultry, beef, hogs
____ Cutting firewood or logs to sell
____ Gathering eggs or working in hatcheries
____ Working on a dairy farm or a catfish farm

Does this student use a language other than English? ____ Is a language other than English used in the home?____

Are you sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason? ____yes ____no

Explain_____

Are you currently residing at a motel, hotel, in a car, or at a campsite because your home has been damaged or because of economic reasons? ____yes ____no

Are you currently residing in a shelter? ____yes ____no

Are you currently living in a temporary housing arrangement due to economic hardship? ___yes ___no

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****Will your child take routine/ daily medication at school? **** No____ Yes____

Will your child take **daily** medications at home? No____ Yes____

Name of medication (s) and reason for taking_____ home or school

Name of medication (s) and reason for taking_____ home or school

DOES YOUR CHILD HAVE:

Trouble seeing? No____Yes____ Wear glasses or contact lenses No___Yes____

Trouble hearing? No____Yes____ Wear a hearing aid? No___Yes____

Insect Sting Allergy No___ Yes___ Describe reaction_____

Any difficulty breathing?_____ Need emergency medication?_____

Does child have an epi-pen? Yes ____ No____Comments_____

*** If **YES** Please bring epi-pen to nurse's office with prescription label ***

Asthma No___ Yes___ Triggered by: _____ Treatments_____

Diagnosed by doctor_____ Date: _____

Will your child need treatments or an inhaler at school? No ____ Yes ____

*** If **YES** Please bring inhaler/ medication to nurse's office with prescription label ***

Allergies No___ Yes___ To drugs or food? Please list:_____

Has the allergy required emergency action in the past? Yes ____ No____

Does child have an epi-pen? Yes ____ No____Comments_____

*** If **YES** Please bring epi-pen to nurse's office with prescription label ***

Comments_____

Diabetes No___ Yes___ Take insulin? No___ Yes____ Date Diagnosed _____

Will your child be checking blood sugar at school? Yes ____ No____

Epilepsy/Seizures No___ Yes ___ Describe seizures _____

Date of last seizure _____ Medication_____

Is student currently under a doctor's care for seizures? No___ Yes___

Doctor's Name_____

Heart Condition No___ Yes ____ Describe:_____

Any physical restrictions?_____Medication_____

Bone /Joint problem No___ Yes___ Describe:_____

Any physical restrictions?_____

Other illness No ___ Yes ___ Describe _____

Has your child had:

Serious illness?	No____Yes____	Specify_____
Serious injury?	No____Yes____	Specify_____
Surgery?	No____Yes____	Specify_____
Childhood diseases?	No____Yes____	Specify_____

Other Concerns: Please circle/ check all that apply. Nosebleeds ___ frequent ear infections___ tubes in ears___

Bowel - requires diapering No___ Yes____ Bladder - requires catheterization? No___ Yes___ bedwetting ___

Dental___ Blood disorders___ Neurological ___Lungs___ Headaches____ Blood pressure_____ Menstration___ Phobias (fears)___

Other health concern not addressed above: (Please explain) _____

_____

***** If your child will require medication at school, a change in P.E. participation, or has any special health concerns please obtain the appropriate form in the Nurse's office. *** ****Please see Medication Policy for medication administration******

SIGNATURE OF LEGAL PARENT/GUARDIAN _____ DATE_____

DORA R-III SCHOOL MEDICATION CONSENT FORM

Name_____ Grade_____

Drug Allergies (Be Specific) _____

Significant Heath Problems_____

Doctor Monitoring Health Problem_____

The Dora R-III School District has my permission to administer the following Over-the-Counter medications checked below:

___ Tylenol. **Approximately 10mg/kg orally every 6 hours, for pain or fever.**

___ Ibuprofen. **Approximately 10mg/kg orally every 6 hours, for pain or fever.**

___ Antacid. **An over-the-counter brand, one or two routine doses/day for heartburn or** indigestion or upset stomach.

___ Calamine Lotion. **For irritated or itchy skin, as needed.**

___ Hydrocortisone 0.5% cream or ointment. **Up to three times a day for poison ivy or eczema.** Not for use on the face more than one week running.

___ Anbesol. **For canker sore or tooth ache, as needed.**

___ Benadryl. **For allergic reaction or severe allergies.**

Parent/Guardian Signature _____Date_____

Medications will not be given, unless the policy outlined in the Handbook is followed.

Shana Hambelton, RN
School Nurse