□ Big Sky □ Hellgate
□ Sentinel □ Seeley Swan
□ Willard (Check home school too)

STUDENT HEALTH RECORD

Missoula County Public Schools

Graduation Year:

Student's Name:_____ Sex:_____ Birthdate: _____
Last First Middle

Student's Address:_____ Home Phone: _____

Father's Name:_____ Work Phone: _____
Last First

Mother's Name:_____ Work Phone: _____
Last First

Legal Guardian's Name:_____ Phone: _____

In case of accident or emergency, contact: Name:_____ Phone: _____
Name:_____ Phone:_____

In the case of accident or serious illness, the school will provide first aid and contact the parents to obtain further medical attention. The school may notify emergency services if deemed necessary. If appropriate and the school is unable to contact the parent, the school may contact the medical provider listed below and follow his/her instructions.

Health Care Provider (HCP):_____ **Phone:** _____
Hospital Preference: _____

Student Health History

The information that you provide about your child's health conditions may be disclosed to school staff to ensure your child's health, safety and accommodations as needed.

□ **Non-allergic food intolerances:** To what with what symptoms**:**_____
□ **Allergies:** To what? (Medicines, food, etc.) _____
Symptoms your child had: _____
What medications were used to treat those symptoms? _____
Has your child ever been given a written prescription for epinephrine (Epipen)? Yes * No
□ **Asthma OR Reactive Airway Disease:** What "triggers" or causes asthma symptoms in your child?
□ Exercise □ Respiratory infection □ Change in temperature □ Animals □ Foods_____
□ Strong odors or fumes □ Dust □ Pollens □ Molds □ Carpets in rooms □ Other _____
Daily Asthma Medications: _____
Emergency Asthma medications: _____
□ **Concussion History:** Number and approx. dates of concussion(s): _____ Was concussion diagnosed by a health care provider? (doctor, etc.) □ Yes □ No Other: _____
□ **Diabetes:** Type:_____ Medications:_____ □ Pump □ Injections
□ **Seizures:** Type:_____ Date of last seizure: _____
Current anti-seizure medications: _____
□ **Hearing loss or impairment:** Describe:_____ □ Wears hearing aid
Is the hearing loss significant enough that your child may need accommodations? □Yes □ No
□ **Vision Impairment:** Describe: _____ Wears glasses or contacts? □Yes □ No
Is the vision problem significant even with glasses/contacts that your child may need accommodations? □Yes □ No
□ **Surgeries:** Type and Date: _____
□ **Hospitalizations:** Date and cause: _____
□ **Other Health Conditions, physical restrictions or medication at home that may require consideration at school**:

_____

_____

NO MEDICATION, OVER THE COUNTER OR PRESCRIPTION, WILL BE ADMINSITERED WITHOUT PROPER Health Care Provider /PARENT SIGNATURES. See school nurse for form

Date: _____ **X** _____
Parent/ Legal Guardian Signature