Missouri School for the Blind
2024-2025
Health Center Illness Information

<u>If you think your child is sick, please do not send him or her to school.</u>

24 Hour Keep at Home Rule – If your child has any of the following symptoms, please keep your child home for 24 hours after the last symptom before sending your child back to school. If your child has a cold please keep them at home if she or he is i.e., sneezing, coughing, nose running profusely and fever.

- **Diarrhea**
- **Rash**
- **Vomiting**
- **Pink Eye**
- **Fever**
- **Red Eye**

Contagious Illness – The Department of Health requires that your report to the school immediately if your child has received a diagnosis of a contagious condition. Please call the Health Center at (314) 633-3921.

- **Pink Eye**
- **Strep Throat**
- **Scarletina**
- **Food Poisoning**
- **Whooping Cough**
- **Coxsackie Virus**
- **Meningitis**
- **Chicken Pox**
- **Pin Worms**
- **Tuberculosis**
- **Measles**
- **Mumps**
- **Polio**
- **Lice**
- **Shingles**
- **Hepatitis**

1. If your child gets sick at school or arrives at school sick, you will be contacted, and may have to pick up your child. It is imperative that someone is available to take your child home if he or she is ill.
2. We cannot act in your place if your child is sick. You must make decisions about your child.
3. If your child becomes sick before boarding the school vehicle to return home, depending on the seriousness of his or her condition, it will be your responsibility to come to school and take your child home as soon as possible from the school or from the hospital.
4. Any child who is absent from school due to illness must return to school with a note to the Health Center. This note can be provided by the parent, unless a note from the doctor was specifically requested. Should your child have any serious illness, especially one requiring hospitalization or surgery, a note **must** come from the treating physician. The note should state what activities the child may participate in or any restrictions as a result of the treatment.
5. MSB must have your up-to-date phone number and address. Please advise us of any changes immediately by calling the Health Center at (314) 633-3921.

Missouri School for the Blind
Consent for Services 2024-2025
Annual Update Report

TO PARENTS/LEGAL GUARDIANS OR THE RESPONSIBLE SOCIAL AGENCY: In order to better serve the students at MSB, please complete this form. (This information will be kept confidential). Thank you for your cooperation. Complete each section in its entirety for accurate information.

A. Students Name:_____ Birthdate:_____
Social Security #:_____

B. Name of Parent(s) or Legal Guardian:_____
Address:_____ City/Zip:_____
County:_____ Phone: ( )_____

***If you are the legal guardian (other than the natural parent) please submit copies of legal court documentation prior to the start of school.**

C. If the student is living with someone other than the parent/legal guardian, please indicate person(s)/agency name:_____

Relationship:_____ Address:_____

Phone: ( )_____ City/Zip:_____

County:_____

D. Father, stepfather, foster father (circle one)

Name:_____

Address:_____ City/Zip:_____

Phone:_____ Age:_____ Occupation:_____

Employer:_____ Work Phone: _____

E. Mother, stepmother, foster mother (circle one)

Missouri School for the Blind
Consent for Services 2024-2025
Annual Update Report

Name:_____

Address:_____ City/Zip:_____

Phone:_____ Age:_____ Occupation:_____

Employer:_____ Work Phone: ( )_____

F. Does the student receive S.S.I. benefits? ____ Yes ____NO (if no, have you applied to social security administration to determine if he/she is eligible for S.S.I? ___ Yes ___ No Contact the school social worker at (314) 776-4320, if you need additional information about S.S.I. benefits.

G. Other persons in the household:

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____

H. Does your child receive services from the following agencies:

Regional Center ____ Yes ____ No
Address:_____ City/Zip:_____
Contact Person:_____ Phone: ( )_____
Division of Family Services: ___ Yes ___ No
Address:_____ City/Zip:_____
Contact Person:_____ Phone: ( )_____

Rehab Services for the Blind: ___ Yes ___ No

Address:_____ City/Zip:_____
Contact Person:_____ Phone: ( )_____

I. **GUARDIANSHIP:** At age 18, individuals become adults, and are authorized to make legal decisions regarding their welfare. Some MSB students, by reason of disability or mental capacity, are not able to make their own

decisions. Those students need guardians appointed to represent them when they turn 18. If your child is 17 or older, please answer the following questions:

Is your child likely to require a guardian at age 18? ___Yes ___No

Have you applied for guardianship for your child? ___Yes ___No

Do you need information about filing for guardianship? ___Yes___No

If you have any questions about resources available for your child, please call Melissa Lampe at (314) 633-1559.

☐ Student is his/her own guardian and is authorized to make legal decisions regarding their personal welfare. This includes signing consents, requesting and taking over the counter medications. Student may be responsible for acquiring, taking, and safekeeping prescribed medications

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF SPECIAL EDUCATION - MISSOURI SCHOOLS FOR THE BLIND

EMERGENCY OR ILLNESS FORM

PARENT/GUARDIAN(S) ARE RESPONSIBLE FOR ADVISING THE SCHOOL WHEN CHANGES ARE NEEDED TO THE INFORMATION PROVIDED ON THIS FORM.

STUDENT'S NAME	DATE OF BIRTH
HOME ADDRESS	

PARENT/GUARDIAN 1 INFORMATION

NAME	TELEPHONE
EMAIL ADDRESS	
PLACE OF EMPLOYMENT	EMPLOYMENT TELEPHONE

PARENT/GUARDIAN 2 INFORMATION

NAME	TELEPHONE
EMAIL ADDRESS	
PLACE OF EMPLOYMENT	EMPLOYMENT TELEPHONE

IF PARENTS CANNOT BE REACHED IN CASE OF SUDDEN ILLNESS OR ACCIDENT, LIST TWO PEOPLE THE SCHOOL MAY CONTACT AND/OR WITH WHOM YOUR CHILD CAN BE LEFT IF NECESSARY.

NAME 1	NAME 2
ADDRESS	ADDRESS
TELEPHONE HOME	TELEPHONE HOME
TELEPHONE WORK	TELEPHONE WORK

MEDICAL INFORMATION IF EMERGENCY TREATMENT IS REQUIRED AND THE PARENT/GUARDIAN(S) CANNOT BE REACHED IMMEDIATELY, THE SCHOOL AUTHORITIES WILL CALL THE DOCTOR LISTED BELOW AND, IF NOT AVAILABLE, AN ALTERNATE MEDICAL CARE RESOURCE MAY BE UTILIZED TO PROVIDE EMERGENCY CARE.

PREFERRED HOSPITAL	HOSPITAL ADDRESS
DOCTOR TO BE NOTIFIED	DOCTOR TELEPHONE
DOCTOR'S ADDRESS	
DENTIST TO BE NOTIFIED	DENTIST TELEPHONE
DENTIST'S ADDRESS	

ALL KNOWN ALLERGIES	ALL REACTIONS TO DRUGS
DIET RESTRICTIONS	DATE OF LAST TETANUS BOOSTER
IF STUDENT TAKES ANY MEDICATION ON A REGULAR BASIS, PROVIDE NAME/DOSE/FREQUENCY	

PARENT/GUARDIAN 1 SIGNATURE	DATE
PARENT/GUARDIAN 2 SIGNATURE	DATE

Missouri School for the Blind
Consent for Services 2024-2025

Student's Name:_____

Authorization to Release Information
2024-2025

We (I) the parent/legal guardian of _____
Give permission to the MSB Health Center staff to release all records and reports related to the health and well-being of the above named student to physicians and therapists and pharmacists as stated per the HIPA/FERPA guidelines.

Parent/Guardian Signature:_____ Date:_____

Do Not Write Below This Line

Person/Institution Requesting Information

Name:_____

Institution:_____

Address:_____

Phone:_____

Information Requested:_____
_____
_____
Period From_____ To_____

Name of Parent Notified:_____ Date_____
Per ☐ Mail ☐ Phone ☐ Fax
By:_____ Date_____

Missouri School for the Blind
Consent for Services 2024-2025
Authorization to Refer & Share Information With Outside Medical/Clinical Services

From:_____ To:_____

Address:_____ Re:_____

_____ _____

I (we) the undersigned do hereby authorize Missouri School for the Blind to refer my child to the appropriate clinical resources within the community for evaluation and community based if needed. The Missouri School for the Blind is authorized to share and receive information with/from any person, firm physician, clinic, hospital, or agency, public or private. I (we) the undersigned release Missouri School for the Blind and cooperating professional, individual, or agency from liability for information shared pursuant to this authorization.

Results of professional evaluations or recommendations may be shared with the parent/legal guardian.

Signed_____
(Parent/Legal Guardian)
Address_____
City/State_____ Zip_____
Telephone#_____
Date_____

Witnessed:

_____
_____

***We will need to transfer medical information to other agencies throughout the school year when necessary (fire dept., police, ambulance, emergency staff, hospital, etc.)**
*** This form will be copied as needed throughout the school year.**

MEDICAL STATEMENT FOR STUDENT REQUIRING MEAL MODIFICATION

Name of Student	**Date of Birth**
Name of Parent/Guardian	**Parent/Guardian Contact Phone**
Local Education Agency	**School Attending**

For Completion By Medical Authority: *Physician (M.D. or D.O.), Physician's Assistant, Assistant Physician or Nurse Practitioner*

Identify the child's physical or mental impairment and how it restricts the child's diet, including allergies, requiring the student to have a modified diet.

Explanation of what must be done to accommodate the child.

Omitted Foods Listed Below	**Substitute Foods Listed Below**	
Medical Authority Printed Name	**Title**	
Medical Authority Signature	**Telephone Number**	**Date**

Parent/Guardian Permission: *To be completed by a parent/guardian*

I give permission for school personnel responsible for implementing my child's prescribed diet order to discuss my child's special dietary accommodations with any appropriate school staff and to follow the prescribed diet order for my child's school meals. I also give permission for my child's medical authority to further clarify the prescribed diet order on this form if requested to do so by school personnel.

Signature of Parent/Guardian	**Date**

Important! Local Education Agencies are required to make substitutions to meals for children with a disability that restricts the child's diet on a case-by-case basis and only when supported by a written statement from a State recognized medical authority.

Modifications to Accommodate a Disability: A school is required to make meal modifications prescribed by a medical authority to accommodate a student's disability.

Definition of Disability:
Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA), and Departmental Regulations of 7 CFR part 15b define a person with a disability as any person who has a physical or mental impairment which substantially limits one or more major life activity, has a record of such impairment, or is regarded as having such an impairment.

Major life activities are broadly defined and include, but are not limited to caring for one's self, eating, sleeping, performing manual tasks, walking, standing, lifting, bending, seeing, hearing, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. Major life activities also include operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

The Department of Elementary and Secondary Education does not discriminate on the basis of race, color, religion, gender, national origin, age, or disability in its programs and activities. Inquiries related to Department programs and to the location of services, activities, and facilities that are accessible by persons with disabilities may be directed to the Jefferson State Office Building, Office of the General Counsel, Coordinator – Civil Rights Compliance (Title VI/Title IX/504/ADA/Age Act), 6th Floor, 205 Jefferson Street, P.O. Box 480, Jefferson City, MO 65102-0480; telephone number 573-526-4757 or TTY 800-735-2966; fax number 573-522-4883; email civilrights@dese.mo.gov.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992.

Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Missouri School for the Blind
Consent for Services 2024-2025

Students' Name: _____

Health Center Information

2024-2025

As a school based Health Center, we are required to have written physician's orders to authorize the dispensing and use of all medications prescribed. This includes all prescribed herbal supplements and over the counter medications, including first aid ointments.

Parents/Guardians, are responsible for obtaining initial orders before the beginning of each school year. Please have your physician mail or fax medications orders to cover all of your child's medical needs/treatments for this coming school year. Medication will only be given as prescribed by the health care provider. Attached is the MSB As Needed Medication List. These medications can be given on an as needed basis to treat short term illnesses such as headaches, eye pain/dryness, muscle pain, upset stomach, allergy/cough, etc…

- MSB will contact the doctor for as needed medication orders
- Parents are responsible for sending pharmacy bottles with the original/up to date labels (please do not use old bottles).
- Please provide all medications, ointments, etc. in a 30-day supply.
- If your child becomes ill while at school, the Health Center will notify you at the earliest opportunity.
- In the event of illness, injury, or other condition requiring a higher level of care, your child will be transported to a local hospital or urgent care. A representative of the Health Center will contact you with any pertinent information. IF you cannot be reached, a voicemail will be left for you.
- MSB Health Center does not administer immunizations. It is your responsibility to have your child immunized. We monitor your child's immunization record for compliance with the Missouri Department of Health. We will notify you when immunizations are needed.

Missouri School for the Blind
Consent for Services 2024-2025

Health Center

Information 2024-2025

- MSB does not provide medical insurance for students. Cost for medical care, medication (and at times, therapy equipment) will be billed to your insurance/Medicaid. **Please provide the Health Center with copies of all insurance cards.**
- Students are not able to keep medications on their person or in their possession. Always direct **all** medications to the Health Center.
- Always make sure to check your child out of school through the Health Center for early pickups and late drop offs.
- Always read Health Center correspondence each week to maintain communication and continuity of care.
- Always feel free to contact the Health Center with questions, information about your student's conditions, treatment, temperament, etc… at 314.633.3921 (Health Center) or 314.633.3936 (Jennifer Morton, RN, Nurse Supervisor).

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
MISSOURI SCHOOL FOR THE BLIND

PARENTAL NOTIFICATION AND CONSENT TO ACCESS PUBLIC INSURANCE AND TO RELEASE PERSONALLY IDENTIFIABLE INFORMATION

STUDENT NAME	DATE OF BIRTH	SCHOOL

REASON FOR CONSENT

With your consent, Missouri School for the blind (MSB) is allowed to disclose to MO HealthNet (Medicaid) Division records or information about the services that may be provided to a particular child for the purpose of billing for applicable services provided through an Individualized Education Program (IEP) under the Individuals with Disabilities Education Act (IDEA) by accessing you or your child's public insurance.

The MO HealthNet (Medicaid) Division School-Based Services Program in Missouri

- provides partial reimbursement to school districts for services that include: Occupational Therapy, Physical Therapy, Speech/Language Therapy, Behavioral Health Services, Audiology/Hearing Services, Private Duty Nursing, Personal Care Services and Transportation.
- does not affect a family's MO HealthNet (Medicaid) insurance benefits.
- helps MSB to offset some of the costs of services provided through an IEP.
- is voluntary and requires a parent or guardian to provide written consent for MSB to release information about their child and seek reimbursement from MO HealthNet (Medicaid) Division to help pay for services provided through an IEP.

If your child receives any of the services listed above and qualifies for/has MO HealthNet (Medicaid) coverage, parent/legal guardian permission is requested to release information to enable MSB to access MO HealthNet (Medicaid) Division public insurance for reimbursement of school-based services.

CONSENT

By signing below, you agree to the following:

I understand and give MSB permission to access my or my child's public insurance benefits. I understand my child's educational records and information about the services my child receives through the IEP will be released in order for MO HealthNet (Medicaid) Division to help pay for IEP services.

- I understand this may include sharing information with the MO HealthNet (Medicaid) Division, their contracted billing agent and/or a physician to obtain necessary documentation (e.g., physician scripts, referrals) to receive reimbursement for services provided through an IEP.
- I understand information to be released may include, but not limited to, the child's name, birthdate, Medicaid ID or other identification, disability, IEP and evaluations, type of service(s), times and dates services were delivered, and progress notes.
- I understand MSB may not require me as a parent to sign up for or enroll in public benefits or insurance programs in order for my child to receive a free appropriate public education under Part B of the Individuals with Disabilities Act,
- I understand MSB may not require me as a parent to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services provided pursuant to this part, but may pay the cost that the parents otherwise would be required to pay.
- I understand MSB may not use a child's benefit under a public benefits or insurance program if that use would: decrease available lifetime coverage or any other insured benefit; result in the family paying for services that would otherwise be covered by the public benefits or insurance program and that are required for the child outside of the time the child is in school; increase premiums or lead to the discontinuation of benefits or insurance; or risk loss of eligibility for home and community-based waivers based on aggregate health-related expenditures.
- I understand that this consent will remain in effect at all times MSB is responsible for providing IEP services to my child, unless revoked by me, and that I may revoke my consent at any time by notifying MSB in writing.
- I understand that refusal to provide consent or revoking my consent to disclose personally identifiable information to MO HealthNet (Medicaid) Division does not relieve MSB of its responsibility to ensure that all required IEP services are provided to my child at no cost to me as the parent.

PARENT/LEGAL GUARDIAN NAME	PARENT/LEGAL GUARDIAN SIGNATURE	DATE

Missouri School for the Blind
Consent for Services 2024-2025
Student Insurance Information

Student's Name:_____

SSN:_____

Primary Insurance:_____

Policy#:_____ Group#:_____

Medicaid#:_____

***Please attach a copy of your child's insurance card. Thank you.**
If the insurance is managed care, please give the name of the HMO._____

Primary Care Physician:

Name:_____

Address:_____

Hospital Name:_____ Phone:_____

Insurance Case Manager Name (if applicable):_____ Phone:_____

Other Physicians:

Name	Phone Number	Specialty	Seen In Last 12 Months:
_____	_____	_____	Y ☐ N ☐
_____	_____	_____	Y ☐ N ☐
_____	_____	_____	Y ☐ N ☐
_____	_____	_____	Y ☐ N ☐

Secondary Insurance:_____
Policy#:_____ Group#:_____

***Please attach a copy of your child's secondary insurance card. Thank you.**
The insurance is managed care.
Please give the name of the HMO (Health Maintenance Organization)_____

Missouri School for the Blind
Consent for Services 2024-2025

Student's Name:_____

Consent for Psychological / Social Services 2024-2025

***Please check one of the following boxes.**

☐ We (I) consent to the assessment, evaluation, and possible treatment by the contracting agency Missouri School for the Blind to address the psychological / social needs as indicated. We (I) give consent to Missouri School for the Blind (MSB) staff to provide assessment and council to our child, and refer our child to the appropriate MSB staff. I also give permission to share my insurance information with the contracted agency for psychological services and assessments rendered to my child.

☐ We (I) do not consent for psychological / social services to be provided by Missouri School for the Blind. I will provide those services for my child through a private practice.

Parent/Guardian Signature: _____ Date: _____

Relationship to Student: _____

IMPORTANT:
I authorize the Missouri School for the Blind to **Release** my child's insurance to a secondary institution for any psychological services received at MSB. Such as: counseling, testing and any mental health issues.

Parent/Legal Guardian Signature:_____
Date:_____
Relationship to Student:_____

Missouri School for the Blind
Consent for Services 2024-2025

Student's Name:_____

Consent to Therapy Services 2024-2025

***Please check one of the following boxes.**

☐ We (I) consent to hearing evaluation/screening and scoliosis screening provided by the Missouri School for the Blind staff.

☐ We (I) do not consent to hearing evaluation/screening and scoliosis screening provided by Missouri School for the Blind staff. We will provide the MSB nurses with a copy of audiology results.

☐ We (I) consent to therapy services provided by the Missouri School for the Blind staff of physical, occupational and speech/language therapists and audiologists. These services are provided to support the educational goals as designated in the IEP.

☐ We (I) do not consent to therapy services provided by the Missouri School for the Blind staff of therapists.

Parent/Guardian Signature:_____ Date:_____

Relationship to Student:_____

Missouri School for the Blind
Consent for Services 2024-2025

Student's Name: _____

Urgent Care and / or Emergency Treatment
2024-2025

***Please check one of the following boxes.**

☐ We (I) the parent/legal guardian of _____ consent to urgent treatment at a clinic, office or hospital and/or emergency treatment at a local hospital as deemed necessary by the Missouri School for the Blind Health Center staff. We (I) consent to treatment, surgery, anesthesia, admission and discharge as deemed necessary by the attending physician. We (I) authorize the Missouri School for the Blind to release to the physician, hospital or clinic any relevant information necessary for treatment.

☐ We (I) do not authorize the treatment of our child by a hospital, clinic, etc. in case of an emergency. We would like to be notified and consulted prior to.

Parent/Guardian Signature:_____ Date:_____

Relationship to Student:_____

Please send a copy of your child's Medicaid or private insurance card. It is very important that we maintain a copy of this for our record.

Missouri School for the Blind
Consent for Services 2024-2025

Student's Name:_____

Consent for Health Center Services 2024-2025

- ☐ As the parent(s) or legal guardian of

  _____

  We (I) do consent to Health Center services provided by the Missouri School for the Blind Health Center staff of nurses, and appropriately trained assistive personnel. These services may include assessment, treatment, medication administration, and first-aid as stated in the Health Care Plan/Physician's Orders.

- ☐ I understand that I need to take our (my) child to a private ophthalmologist/optometrist annually. We will provide the Health Center with the annual results from a licensed ophthalmologist/optometrist.

***Missouri School for the Blind does not offer ophthalmologist/optometrist services.**

Parent/Guardian Signature: _____ Date: _____

Relationship to Student: _____

1. Sign and return annual consents
2. Send a copy of **ALL** insurance cards
3. Send Immunization updates
4. Send Annual vision exam
5. Please send Annual physical or sports physical
6. Please send a copy of legal guardianship papers if not on file.

Missouri School for the Blind
Consent for Services 2024-2025

COVID-19 TESTING CONSENT FORM

Student Name: _____

Date of Birth: _____ Gender: _____ Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____County: _____

COVID-19 Vaccination Status

Please read the following choices and choose the most appropriate response.

- ☐ My child **has been** vaccinated against COVID-19. Please attach copies of your child's updated immunization record.
- ☐ My child has not been vaccinated against COVID-19.
- ☐ My child can go without a mask until otherwise notified by a parent or a guardian
- ☐ My child must wear a mask until otherwise notified by a parent or a guardian

Informed Consent for COVID-19 Rapid Antigen Testing

Important – This test will only be administered if the child is exhibiting Covid symptoms.

Please carefully read the following informed consent:

1. I authorize MSB Health Center Personnel to conduct the BinaxNOW Rapid Antigen Covid-19 test through a nasopharyngeal swab on my child.
2. I authorize test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.
3. I acknowledge that a positive test result is an indication that my child must self-isolate in an effort to avoid infecting others.
4. I understand that, as with any medical test, there is potential for false positive or false negative test results.
5. I understand I will be notified of the results as soon as available by the health center personnel via phone.

Patient/Guardian Signature_____ Date_____

Relationship to Patient_____

Missouri School for the Blind
Health Center
Consent for Services 2024-2025

Student's Name:_____

Authorization to Receive Medical Information 2024-2025

We (I) the parent/legal guardian of _____
Give authorization to the Missouri School for the Blind Health Center to obtain medical information including records from inpatient/outpatient hospital stay, doctors' office and clinical visits. This includes but is not limited to the name of the treating physician, treatment summaries, discharge instructions, list and indications for all medications, therapies, treatments, testing, and diagnostics. This also includes copies of prescriptions or doctors' orders from pharmacists and pharmaceutical companies.

We also give permission for the health center staff to obtain health records from previous schools, institutions and social services, which may include: immunization and medication history, eye exams, audiology reports and physician history and physicals.

Parent/Guardian Signature:_____ Date:_____

MISSOURI DEPARTMENT OF ELEMENTARY AND
SECONDARY EDUCATION
MISSOURI SCHOOLS FOR THE SEVERELY DISABLED
P.O. BOX 480
JEFFERSON CITY, MO 65102-0480

IMMUNIZATION REQUEST

According to our records _____ is in need of the following checked (✓) immunizations to meet the requirements for school attendance under Missouri State Immunization Law (Section 167.181 RSMo):

✓	TYPE OF IMMUNIZATION NEEDED	DATE OF LAST IMMUNIZATION	DATE OF NEW IMMUNIZATION
	DTaP/DTP/DT/Td [dose(s)]		
	Tdap		
	Td/10 year booster		
	Inactivated Polio [dose(s)]		
	MMR [dose(s)]		
	Hepatitis B [dose(s)]		
	Varicella [dose(s)]		
	Meningococcal [dose(s)]		
	Indicate type: ☐ MCV4		
	☐ MenACWY		
	Other:		
	Other:		
	Other:		

If this student **has** had the immunization(s) checked above since the date(s) noted, please provide a copy of the official immunization record to school as soon as possible. This must be received by _____ (date) or the student will be excluded from attending school.

If this student **has not** had the immunization(s) checked above since the last date(s) noted, please arrange to have the immunization(s) given as soon as possible. After the immunization is received, please have the healthcare provider fill in the "date of new immunization" above and sign below. Also, please provide a copy of the official immunization record to school as soon as possible. The student will be **excluded** from attending school if this form is not returned to school by _____ (date).

School Nurse's Signature	Date

Full Name of Healthcare Provider (Print)	Signature of Healthcare Provider	Date

Missouri
DEPARTMENT OF ELEMENTARY & SECONDARY
EDUCATION

MISSOURI SCHOOL FOR THE BLIND

CONSENT FOR ADMINISTRATION OF OVER THE COUNTER MEDICATIONS

We require a doctor's order for all medications including over the counter. Please have your student's doctor fill out this form and return it to MSB.

Name: _____ DOB: _____

Allergies: _____

Medication	Dosage	Give	Frequency	Route	As Needed
Ibuprofen	200 mg tablet 100mg/5ml	___ tablets ___ ml	Every 6 hrs.	By mouth	As need for Pain/ fever
Tylenol	325 mg tablet 160mg/5ml	___ tablets ___ ml	Every 4-6 hrs.	By mouth	As need for Pain/ fever
Diphenhydramine	25mg tablet 15mg/5ml	___ tablets ___ ml	Every 6 hrs.	By mouth	As need for itching/ allergies
Banophen	12.5mg/5ml	___ ml	Every 6 hrs.	By mouth	As need for itching/ allergies
Zyrtec	10 mg	1 tablet	Once a day	By mouth	As needed for allergies
Tums/Antacid Tablets	500mg tablet	___ tablets	Every ____ hrs.	By mouth	A needed for indigestion/ heartburn
Mylanta		___ ml	Every 4 hrs.	By mouth	As needed for indigestion/ heartburn
Pepto Bismol	30 ml	30 ml	Every hour do not exceed 8 doses/24 hours	By Mouth	As needed for upset stomach
Milk of Magnesia		___ ml	Daily	By Mouth	As needed for constipation if no BM in ___days. Contact MD if No BM in ___days

3815 Magnolia Avenue, St. Louis, Missouri 63110
(314) 776-4320
Fax (314) 776-1875
www.msb.dese.mo.gov

Medication	Dosage	Give	Frequency	Route	As Needed
Loperamide Hydrochloride	2mg tablet	___ tablets	Every____ hrs.	By mouth	As needed for diarrhea do not exceed _____mg within 24 hours
Robitussin DM		___ ml	Every 4-6 hrs.	By mouth	As needed for cough or congestion
Cough Drops		___ tablets	Every ___ hrs.	By mouth	As needed for cough or congestion
Triple Antibiotic Ointment		Apply		Topically	As needed for first aid
Dibucain Ointment		Apply		Topically	As needed for bug bites, itching
Zinc Oxide Barrier Cream		Apply		Topically	As needed for rash
Hydrocortisone Cream		Apply	2-3 times a day	Topically	As needed for rash, itching
Calamine Lotion		Apply	3-4 times a day	Topically	As needed for rash, itching

For any questions, contact Missouri School for the Blind Health Center at 314-633-3921.

Physician Name: _____

Physician Signature: _____

Physician Phone Number: _____ Date: _____

3815 Magnolia Avenue, St. Louis, Missouri 63110
(314) 776-4320
Fax (314) 776-1875
www.msb.dese.mo.gov

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF SPECIAL EDUCATION – MISSOURI SCHOOLS FOR THE BLIND

MEDICATION ORDER

INSTRUCTIONS

This form must be completed in order for the student to receive medication(s) at school; this includes both **prescription and non-prescription** medications (including lotion, lip balm, deodorant, diaper rash cream, toothpaste, etc.). The school is not allowed to make any changes to the healthcare provider instructions written on this form. Any changes concerning the medication type, dosage or procedure will require a new form to be completed by the healthcare provider and be on file at the school the student is attending. The medication will be given by the **school nurse or a trained staff member**. The order will be in effect for no longer than **one school year.**

STUDENT INFORMATION

STUDENT NAME	DATE OF BIRTH	SCHOOL

NAME OF PARENT/LEGAL GUARDIAN

ALLERGIES

MEDICATION

NAME OF MEDICATION – GENERIC/BRAND	STRENGTH	DOSAGE	ROUTE	TIMES TO ADMINISTER AT SCHOOL
INSTRUCTIONS				
NAME OF MEDICATION – GENERIC/BRAND	STRENGTH	DOSAGE	ROUTE	TIMES TO ADMINISTER AT SCHOOL
INSTRUCTIONS				
NAME OF MEDICATION – GENERIC/BRAND	STRENGTH	DOSAGE	ROUTE	TIMES TO ADMINISTER AT SCHOOL
INSTRUCTIONS				
NAME OF MEDICATION – GENERIC/BRAND	STRENGTH	DOSAGE	ROUTE	TIMES TO ADMINISTER AT SCHOOL
INSTRUCTIONS				
NAME OF MEDICATION – GENERIC/BRAND	STRENGTH	DOSAGE	ROUTE	TIMES TO ADMINISTER AT SCHOOL
INSTRUCTIONS				
NAME OF MEDICATION – GENERIC/BRAND	STRENGTH	DOSAGE	ROUTE	TIMES TO ADMINISTER AT SCHOOL
INSTRUCTIONS				

PROVIDER INFORMATION

NAME OF HEALTHCARE PROVIDER (M.D, D.O., OR NURSE PRACTITIONER)	PHONE NUMBER
ADDRESS	
SIGNATURE	DATE

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF SPECIAL EDUCATION – MISSOURI SCHOOLS FOR THE BLIND

PHYSICAL EXAMINATION REPORT

STUDENT'S NAME	SEX	DATE OF BIRTH	AGE	SCHOOL NAME

INSTRUCTIONS

This is an important record concerning the student's health. **It is imperative to fill out each item completely.**

EXAMINATION

B/P	PULSE	ALLERGIES: NO ☐ YES ☐ IF YES, PLEASE LIST:	HEIGHT	WEIGHT

SEIZURES	SCOLIOSIS-DEGREE	HISTORY OF VARICELLA: NO____YES_____DATE_____

SYSTEMS EXAMINATION	EXAMINED	NOT EXAMINED	COMMENTS
General Appearance			
Nutritional Status			
Posture/Motor Behavior			
Skin			
Head			
Eyes			
Ears			
Nose			
Throat			
Mouth/Teeth			
Neck			
Heart			
Lungs			
Abdomen			
Bones, Joints, Muscles			
Neurological			
Other:			

Medical Diagnoses	

Please note any health problem, chronic health condition or disability that may affect behavior or health at school:

CHECK APPROPRIATE BOX

Medication Required At School: NO_____YES_____If yes, a Medication Order form AND Parent Authorization for Special Healthcare Procedures and Medication Administration must be completed before medication will be administered at school.

CHECK TO INDICATE WHICH ACTIVITIES ARE APPROPRIATE

IMPORTANT: In my opinion, this student's physical condition **will** allow him/her to participate in the following **adaptive P.E.** activities, which will include direct supervision. For individuals with Down syndrome, this opinion is offered in consideration of the implications of atlantoaxial instability.

ADAPTIVE	Mild	Moderate	Strenuous	Not applicable	ADAPTIVE	Mild	Moderate	Strenuous	Not applicable
Bowling					Jumping				
Rhythmic Activities					Weight Lifting				
Trampoline					Climbing				
Roller Skating					Treadmill				
Running					Tumbling				
Swimming					Wrestling				
Bicycling with head and back support, seat belt and chest strap					Physical Fitness Program (i.e., walking, exercise, etc.)				
P.E. Equipment									

NAME OF HEALTHCARE PROVIDER (M.D., D.O. OR NURSE PRACTITIONER)	TELEPHONE NUMBER
HEALTHCARE PROVIDER'S SIGNATURE	DATE