Windsor Central Supervisory Union

Annual Student Health Form

2017-2018

# FULL Name of Student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male \_\_\_\_\_\_\_ Female \_\_\_\_\_\_\_

**MEDICAL INFORMATION**

**Primary Health Care Provider**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had a physical exam within the last year? **Yes\_\_\_ No \_\_\_\_ Date of Last Exam \_\_\_\_\_\_\_\_\_\_**

**Do you have medical insurance? Yes\_\_\_ No \_\_\_\_**Name insurance company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medicaid # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If no,** please contact Vermont Health Connect to see if your child is eligible for Dr. Dynasaur. This program will provide health insurance. For more information and to see if you qualify, please call 1-855-899-9600 or visit VermontHealthConnect.gov. Would you like more information about Dr. Dynasaur? Yes\_\_\_\_ No\_\_\_\_\_

**DENTAL INFORMATION**

**Dentist** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any oral health problems (i.e., surgery/injury)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had a dental exam within the last year? **Yes\_\_\_ No \_\_\_\_ Date of Last Exam \_\_\_\_\_\_\_\_\_\_**

Do you have dental insurance? Yes\_\_\_ No \_\_\_\_ Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMMUNIZATION RECORDS**

**It is a State law that all children have an up to date immunization record on file before entry into our school.** Please attach a copy of your child’s immunizations to this form.

**IMMUNIZATION REQUIREMENTS**

DTaP/DTP : 5 doses required Polio: 4 doses required

MMR: 2 doses of measles, mumps and rubella required Hepatitis B: 3 doses required

Varicella: 2 doses required - Requirement is waived if parent/guardian signs a form indicating the

student has a history of the disease

## VISION HISTORY

# Date of last eye exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child wear glasses? Yes\_\_\_\_ No\_\_\_\_\_

Does your child have other eye problems or special classroom needs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## HEARING HISTORY

# Date of last hearing exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_By whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have ear or hearing problems (i.e., infection, injury, hearing loss, tubes) or special classroom

considerations/needs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## SIGNIFICANT MEDICAL HISTORY

Hospitalizations/Surgeries/Significant Medical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current/Chronic Health Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Health/Psychosocial Needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List medication that your child takes routinely: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will your child need to take medications during the school day? Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_

**If yes,** what is the name of the medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

It is preferable to arrange for students to take any prescription medication at home whenever possible. If medicines must be taken during the school hours, school policy requires that medication be brought to the school nurse by a parent/guardian in the **original pharmacy containers** with a **health care provider’s order** and a **written parent request.**  Students are **not** allowed to carry medication with them while in school.

Does your child have any allergies? Yes\_\_\_\_\_ No\_\_\_\_\_

Please list type of allergy (food, medication, insect) and reaction (rash/anaphylaxis etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child require an epipen for allergies: Yes\_\_\_\_\_ No\_\_\_\_\_\_

**If yes, epipen and allergy action plan must be supplied to the school from your child’s pediatrician.**

Has a doctor, nurse, or other health care professional EVER said that your child has asthma? Yes\_\_\_\_ No\_\_\_\_ Don’t Know/Not Sure\_\_\_\_\_

If yes, does your child still have asthma? Yes\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_ Don’t Know/Not Sure\_\_\_\_\_\_\_

If yes, will student require an inhaler at school? Yes \_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_

**If yes, an asthma action plan and health care provider order must be supplied to the school from your child’s pediatrician.**

What triggers an asthma attack: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sometimes children exhibit behavior like uncontrolled anger, depression or extreme frustration. Is there anything about your child that worries you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any significant family medical history (i.e., diabetes, seizures, heart, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any other information you think would be important for the school nurse to know about your child?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If you wish your child to be given over the counter medications as needed under the judgment and supervision of the school nurse/designee, please check below.

My child has permission to receive the following medications at school:

**Please mark all that apply:**

\_\_\_\_\_Tylenol/acetaminophen, as directed on bottle - for fever, headache or muscle aches.

\_\_\_\_\_Cough drops - for complaint of cough or mild sore throat without fever

\_\_\_\_\_Ibuprofen/motrin/advil, as directed on bottle - for headache or muscle aches

\_\_\_\_\_Benadryl, 12.5-25 mg - for allergy symptoms or bee stings

\_\_\_\_\_ Calamine or hydrocortisone lotion - for bug bites or skin rashes.

\_\_\_\_\_ Antacid (Tums), 1-2 chewable - for complaint of mild stomachache without fever, nausea or

vomiting (after crackers have been tried for hunger)

\_\_\_\_\_ First aid ointment/antibiotic ointment - for cuts and abrasions

\_\_\_\_\_ Anbesol (oral anesthetic) - for toothache, gum/mouth irritations

\_\_\_\_\_ **I would prefer my child NOT be administered any over the counter medication at school.**

I give permission to the school nurse to exchange information and otherwise assist in the medical management of my child, including direct communication with my child’s medical providers.

Yes\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Permission for Treatment**

In the event of a serious accident or illness, I hereby authorize the school to contact my child’s physician and/or to seek emergency medical care, including transportation to a medical facility. I hereby authorize the physician and emergency room staff to administer care that is deemed necessary. I understand every effort will be made to contact family first.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date