

**ORANGE WINDSOR SUPERVISORY UNION
CHELSEA, NEWTON, TUNBRIDGE, SHARON, SOUTH ROYALTON SCHOOLS**

STUDENT HEALTH INFORMATION

Please complete this form **each year** to update the school nurse: My School _____

Information provided is confidential.

Child's full name _____ Birth Date _____ Grade _____

Home Phone _____ Mailing Address _____

Mother's name _____ Occupation _____

Work location _____ Hours & Phone _____

Father's name _____ Occupation _____

Work location _____ Hours & Phone _____

Emergency Contact (1): _____ Phone _____

Emergency Contact (2): _____ Phone _____

Physician's Name _____ Phone: _____

Date of last well-child/physical exam _____

Did your child receive any immunizations over the summer? (circle) Yes No

Dentist's Name _____ Phone: _____

Date of last visit? _____

In case of an emergency, please understand that the school may call an ambulance and that ambulance personnel choose the most appropriate hospital for transport.

Signature: _____ Date: _____

Occasionally the school nurse needs to contact your child's physician regarding immunizations, medication or other significant health or educationally pertinent medical information. By signing below, I consent to the release of the medical records of my child. I understand this authorization will expire at the end of the school year unless I specify otherwise.

Signature: _____ Relationship to Student: _____ Date: _____

PLEASE BE SURE TO COMPLETE BOTH SIDES OF THIS FORM

CONFIDENTIAL HEALTH FORM
Current Health

Diet/Allergy/Medical Concerns: _____

Current Mental Health Concerns: _____

Is your child in counseling? Yes ___ No ___ If so, with whom _____

Is your child on any medications? Yes ___ No ___ If yes, please list medications below and be sure to include any emergency medications such as inhalers, epi-pen, Benadryl, etc.

Medication _____ Reason _____ Dose _____ Time Given _____

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Medication _____ Reason _____ Dose _____ Time Given _____

Medication _____ Reason _____ Dose _____ Time Given _____

Medication _____ Reason _____ Dose _____ Time Given _____

Does your child have asthma? Yes ___ No ___

Do you have medical insurance? Yes ___ No ___ If so, name of insurance company _____

If the answer is no, may a community resource person contact you? Yes ___ No ___

Other specialists your child may visit _____ Date of last visit _____

Does your child have any need of special attention? _____

For example - Hearing? ___Yes ___No Glasses? ___Yes ___No Other _____

Does your child eat well? ___Yes ___No Does your child sleep well? ___Yes ___No

My child has permission to take acetaminophen (Tylenol) at school if needed. ___Yes ___No

My child has permission to take ibuprofen (Advil) at school if needed. ___Yes ___No

I understand that when the School Nurse is not present, medications are given by non-medical personnel trained by the School Nurse.

Parent Signature

Dated