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? _____

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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 ____

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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

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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