Lamoille Union/GMTCC
Health Information

Please complete all questions and mail or fax to: Lamoille Union, 736 VT 15 W, Hyde Park, VT 05655 - (FAX # 888-2997). Student health forms must be completed and sent into the school every year.

Student Name: _____Date of Birth_____ Grade: _____

Student's Physician: _____ Date of last comprehensive annual well care visit*:_____

***A comprehensive well-care (physical) visit is not an appointment for sickness, injury, or chronic health need.**

Student's Dentist: _____ Date of last exam: _____

Does your child have health insurance? Yes ___ No ____
If no, dial 1-855-899-9600 for Vermont Department of Health Connect info
https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action

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My child has permission to receive the following medications at school according to the instructions on the manufacture's label:

Ibuprofen (Advil) ____ Acetaminophen (Tylenol) _____ Antacid _____ Benadryl _____ Loratadine _____

Has your child had the chicken pox? Yes____ No_____ If so, please provide the month/year _____

Is your child new to **LUHS/LUMS**? ____ **If so, attach immunization records or Fax to 888-2997.**

My doctor's office may share immunization information with the school nurse. Yes _____ No _____

Has a doctor or nurse or other health professional EVER said that your child has asthma? Yes ___No____

If yes, does your child STILL have asthma? Yes____ No____ Don't know/not sure_____

How is it treated? _____

****Please attach an Asthma Action Plan from your provider and prescription order for inhaler use at school.**

Does your child have any Allergies? Please explain:

Does your child have an EPIPEN prescribed by a health professional? Yes ____ No _____

If not, how is their allergy treated? _____

Does your child wear glasses or contacts? Yes___ No ___When was your child's last eye exam?_____

Is your child currently being treated for any physical or emotional health condition (Please explain):

Does your child take any medication (prescription, over-the-counter, or herbal) daily? Yes ___ No ___If so, **please list each medication, the dose, and frequency:**

Does your child need to take any prescription/non-prescription medication at school? If so, please list each medication, the dose, and time needed **and have your child's physician/health provider provide a medication prescription order for the school nurse.**

IN CASE OF EMERGENCY INVOLVING MY CHILD, WHEN I CAN NOT BE REACHED: I hereby given consent to transport my child for medical care and authorize the providers and hospital to give any reasonable and customary medical and health care deemed necessary at my expense. It is understood that I will be financially responsible for all emergency care. **Please be sure that the school has updated emergency contact information.**

_____ _____ _____

*****Signature of parent/guardian** **Relationship to student** **Date**