STUDENT HEALTH INFORMATION

School Year: _____

Name: _____ **Grade Level:** **Advisory:**

THIS INFORMATION (without using student names) IS REQUIRED FOR THE ANNUAL REPORT TO THE VERMONT DEPARTMENT OF HEALTH. PLEASE COMPLETE ALL QUESTIONS. THANK YOU.

PHYSICIAN'S NAME:

-Does your child have health insurance? Yes____ No____

-Has your child had a physical in the last year? Yes____ No____

-Has your child received any immunizations over the summer? Yes____ No____

DENTIST'S NAME:

-Has your child had a dental exam in the past year? Yes____ No____

ADDITIONAL MEDICAL INFORMATION

-Has a doctor, nurse or other health professional EVER said that your child has asthma? Yes____ No____ Not Sure____

-If yes, does your child STILL have asthma? Yes____ No____ Not Sure____

-Does your child have any allergy, health problem or disability that we should be aware of? Yes____ No____

If yes, please specify what the condition is:

_____

_____

-Is your child on medication(s)?: Yes____ No____

If yes, please list the medication(s):

(1) _____ Does it need to be given at school? Yes____ No____

(2) _____ Does it need to be given at school? Yes____ No____

(3) _____ Does it need to be given at school? Yes____ No____

PERMISSION TO GIVE MEDICATION(S)

I GIVE PERMISSION FOR THE SCHOOL NURSE TO GIVE MY CHILD THE FOLLOWING MEDICATION(S): (Please Check)

____ Acetaminaphen (Tylenol)

____ Ibuprofen (Advil)

____ Tums

SIGNATURE for Medication Approval: _____ **Date:** _____

PERMISSION TO TREAT

In the event that your child has a serious accident or sudden illness, the school will use its best judgement in determining if your child should be transported by ambulance to the hospital, while making every effort to reach you.

I GIVE PERMISSION TO GIFFORD MEDICAL CENTER, OR THE CLOSEST HOSPITAL TO THE STUDENT, TO CARE FOR MY CHILD IN CASE OF EMERGENCY IF I CANNOT BE REACHED.

SIGNATURE for Treatment Approval: _____ **Date:** _____

CONSENT FOR SERVICES OF ATHLETIC TRAINER

I HEREBY GIVE CONSENT FOR A CERTIFIED ATHLETIC TRAINER TO PROVIDE SPORTS MEDICINE SERVICES. I UNDERSTAND THAT THERE IS NO CHARGE FOR THESE SERVICES.

SIGNATURE for Athletic Trainer Services: _____ **Date:** _____

Please notify the school with any information that changes during the year.