ADDISON NORTHWEST SCHOOL DISTRICT ANNUAL HEALTH FORM

Student Name:_____Birthdate:_____Grade/Teacher:_____

Parent/Guardian:_____Home Phone:_____

Cell Phone:_____Email:_____

Emergency Contact:_____Phone:_____

Physician:_____ Name of Practice:_____ Hospital Preference:_____	What was the date of your child's last well child visit at their medical home?(mm/yy)_____ Does your child have health insurance? Yes_____ No_____ Name of ins:_____
Dentist:_____ Name of Practice:_____	What is the date of your child's last dental exam at their dental home? (mm/yy)_____ Does your child have dental insurance? Yes_____ No*_____ Name of ins:_____
Current health problems:_____ _____ _____	Has a doctor, nurse, or other health professional EVER said your child has asthma? Yes*_____ No_____ Don't know/unsure_____ *If yes, does your child STILL have asthma? Yes**_____ No_____ Don't know/unsure_____
Current medications:_____ _____ _____ Do any of these need to be given at school? Yes**_____ No_____	Does your child currently have: Diabetes? Yes**_____ No_____ If yes, which type? 1 2 Seizures? **Yes_____ No_____ Glasses or contact lenses? Yes_____ No_____
List of known allergies:_____ _____ _____ Does this allergy require an Epipen? Yes**_____ No_____	**These require annual health plans and additional documentation. The nurse will contact you with details. If you need help with insurance please call 1-800-899-9600 or go to the Vermont Health Connect website at https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action

Please do not leave any questions blank. This information is important for updating our health records and state required reporting. It also will help us provide the best care we can for your child.

Please TURN OVER ➤➤➤

ADDISON NORTHWEST SCHOOL DISTRICT ANNUAL HEALTH FORM

Authorization for Release of Information

Student's Name:_____Birthdate:_____
I hereby authorize the Addison Northwest School District Nurse to request and exchange pertinent information with my child's physician/provider and dentist. I understand that only necessary information will be shared and confidentiality will be protected.

Parent/Guardian Signature:_____Date:_____
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Permission for Treatment

I give permission for the Addison Northwest School District Nurse and/or delegate to administer the following over the counter medications to the child stated above.(Check all that apply)

Acetaminophen (Tylenol)_____
Calcium Carbonate(TUMS)_____
Diphenhydramine(Benadryl)_____
Oragel_____
Calamine lotion_____
Ibuprofen (Advil)_____
Cough Drops_____
Hydrocortisone Cream_____
Antibiotic Ointment_____

Parent/Guardian Signature:_____Date:_____
All prescription medications must have written parent permission and a written order from a physician. This order must include the name of the medication, dosage, route, times it is to be administered, and the reason it is being prescribed. The medication needs to be in a pharmacy labeled bottle and dropped off by a parent or guardian. This is an annual requirement. Please contact your school nurse for details.
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Emergency Treatment

In the event of a serious accident/injury, I hereby authorize the Addison Northwest School District Nurse to contact my child's physician and/or seek emergency medical care including transportation to a medical facility. I hereby authorize the physician and emergency staff to administer care that is deemed necessary at my expense. I understand that every effort will be made to contact the family first.

Parent/Guardian Signature:_____Date:_____
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OFFICE USE ONLY
Delegate Medication Administration

Date/Time	Medication and dose	Route	Initials	Reason