

Cambridge Elementary School
Health/Emergency Form 2024-2025

Student Name: _____ Date of Birth: _____

Mailing Address: _____ City: _____

911 Address: _____ City: _____

Guardian #1 Name: _____ Cell #: _____ Work #: _____

Email: _____

Guardian #2 Name: _____ Cell #: _____ Work #: _____

Email: _____

Who can we contact to care for your child if you are not available?

Name: _____ Relationship: _____ Phone: _____

Where is your home located? _____

Do you consider your residence to be a permanent one for you and your family? _____

Do you live in a motel, hotel, campground or trailer park? _____

If yes, which one? _____

Are you living in emergency housing or housing that is temporary? _____

If your family is not the only family living in your location, check the following that apply

_____ I share my housing with others

_____ I only plan to stay at this residence until I find better housing for my family. My stay here is temporary.

Dental Info

Name of Dentist: _____ Phone # _____ Date of last exam: _____

Are you interested in a dental screening and help with a referral? Yes ___ No ___

Medical Info

Name of Physician: _____ Phone # _____ Date of last exam: _____

Is your child up to date with immunizations? Yes ___ No ___ (include immunization record for Pre K, K, new students)

Does your child take daily medication? Yes ___ No ___ Does it need to be taken at school? Yes ___ No ___

If daily medication is given include the name, dose and time given: _____

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

Acetaminophen (Tylenol) ___ Antacid (Tums) ___ Ibuprofen (Advil) ___ Benadryl ___ Zyrtec ___ Anti itch cream ___ Antibiotic Ointment ___ and Cough Drops ___ to be given as needed?

CHECK approved medications above or NO MEDICATION

*Moisturizing lotion/Vaseline/Aloe gel may be used unless otherwise noted.

**Please note students are NOT allowed to carry prescription or over-the-counter medications on their person (with the exception of certain rescue medications). All medications must be kept in the nurse's office in the original pharmacy/manufacturer labeled container. A medication form needs to be filled out for any medication given at school.

Has your child had the chicken pox? Yes ___ No ___ If so, please provide the month/year

Does your child have any allergies? Yes ___ No ___ If yes, please explain: _____

**Provide an EPI PEN and allergy plan for ANAPHYLACTIC ALLERGIES*

Has a doctor EVER said your child has asthma? Yes ___ No ___ Don't know/not sure ___

If yes, does your child STILL have asthma? Yes ___ No ___ Don't know/not sure ___

Does your child need an inhaler at school? Yes ___ No ___ (If yes, please explain: _____)

**Student will need an asthma action plan and signed medication form in order to administer inhaler at school.*

Does your child have any physical concerns or restrictions? _____

I grant permission to the Cambridge Elementary School and its authorized representatives, to acquire such medical care as my child _____ may require, including examinations, treatment and so forth. The permission is conditioned upon the understanding that in the event of serious illness or the need for hospitalization and/or surgery, the school will use all reasonable efforts to contact me. Failure in such efforts, however, should not prevent the school from providing such emergency treatment as may be necessary for the best interest of the life of the student (for example, administering epinephrine in the case of a severe allergic reaction). I understand that I will be responsible for any medical expenses incurred by my child during this school year. Lamoille North schools will contact emergency services in the event of an emergency requiring their assistance.

Print Name (Parent/Guardian)

Signature (Parent/Guardian)

Health Insurance Information

- My child is covered by _____ for health insurance.
(Company Name)
- If uninsured, call Vermont Health Connect at 1-855-899-9600 or visit <https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action>

I grant permission for Cambridge Elementary School to share my child's medical concerns with the classroom teacher and other staff members as necessary for the safety and health of my child.

Signature (Parent/Guardian)

Date