

School \_\_\_\_\_ Teacher/Grade: \_\_\_\_\_ Year \_\_\_\_\_

**MONADNOCK REGIONAL SCHOOL DISTRICT**

| <b>SCHOOL HEALTH RECORD</b>  |      |              |              |                        |
|--|------|--------------|--------------|------------------------|
| In order to keep your child's health record up to date and provide the best care for your child, please complete this form and return it to the school health office as soon as possible |      |              |              |                        |
| STUDENT'S NAME:  | LAST | FIRST        | MI           | Gender<br>M    F       |
|  |      |              |              | DATE OF BIRTH<br>/   / |
| Address:   |      |              | Town:        |                        |
| Email Address:   |      |              | Home Phone # |                        |
| NAME OF FATHER OR GUARDIAN:  |      | WORK PHONE # |              | CELL PHONE #           |
| NAME OF MOTHER OR GUARDIAN:  |      | WORK PHONE # |              | CELL PHONE #           |

**WE WILL ATTEMPT TO CONTACT PARENTS/GUARDIAN BEFORE EMERGENCY CONTACTS**

|                      |               |               |               |
|----------------------|---------------|---------------|---------------|
| Emergency Contact #1 | Home Phone #: | Work Phone #: | Cell Phone #: |
| Emergency Contact #2 | Home Phone #: | Work Phone #: | Cell Phone #: |

|  |   |
|--|---|
| Student's Physician:                                     | Phone#:                                     |
| Student's Dentist:                                       | Phone#:                                     |
| Does child have health insurance? <u>Circle</u> YES / NO | NH Healthy Families? <u>Circle</u> YES / NO |
| Policy #   | Well Sense? <u>Circle</u> YES / NO          |

I understand the school nurse may share information relevant to my child's health condition with appropriate school personnel, when needed to meet my child's educational, health and safety needs. I give permission to exchange information with my child's physician/counselor for the purpose of referral, diagnosis and treatment. I further agree to exempt Monadnock Regional School District and its agents and servants of all claims as a result of any and all acts performed under this authority.

➔ Signature of Parent or Legal Guardian: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Print Name of Parent or Legal Guardian: \_\_\_\_\_

| <b>Student's Health Conditions (Please check all that apply)</b> |  |   |
|--|--|---|
| <input type="checkbox"/> ADD OR ADHD                             | <input type="checkbox"/> Eczema                  | <input type="checkbox"/> Uses hearing aid           |
| <input type="checkbox"/> Allergies (food, insect, etc.)          | <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Poor vision                |
| <input type="checkbox"/> Allergies (MEDICATIONS)                 | <input type="checkbox"/> Tubes in ears           | <input type="checkbox"/> Wears glasses all the time |
| <input type="checkbox"/> Asthma                                  | <input type="checkbox"/> Frequent headaches      | <input type="checkbox"/> Wears glasses reading only |
| <input type="checkbox"/> Dental Problems                         | <input type="checkbox"/> Migraines               | <input type="checkbox"/> Seizures or Epilepsy       |
| <input type="checkbox"/> Depression                              | <input type="checkbox"/> Heart problems          | <input type="checkbox"/> Sinus problems             |
| <input type="checkbox"/> Diabetes                                | <input type="checkbox"/> Poor hearing            | <input type="checkbox"/> Other                      |

Please explain all checked items and the treatments used:

---



---



---

Please complete other side

**What medications does this child receive on a daily basis?**

|    | <u>Medication</u> | <u>Reason for taking</u> |
|----|-------------------|--------------------------|
| 1) | _____             | _____                    |
| 2) | _____             | _____                    |
| 3) | _____             | _____                    |
| 4) | _____             | _____                    |

Does your child have an Epi-Pen? Circle YES / NO

Has the child been taught how to use an Epi-Pen? Circle YES / NO

Please list any severe illnesses, injuries or hospitalizations that the student has had and the date of each:

---



---



---

Are there any other concerns that you would like to share about your child?

---



---



---

**I give permission for the school nurse, or designated personnel, to administer the following medications, if necessary, during the school day: *(Please check and initial next to all that apply)***

| ✓                        | Initial                  |                            |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Tylenol (Acetaminophen)    |
| <input type="checkbox"/> | <input type="checkbox"/> | Advil (Ibuprofen)          |
| <input type="checkbox"/> | <input type="checkbox"/> | Benadryl (Diphenhydramine) |

| ✓                        | Initial                  |                 |
|--------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Anti-Itch Cream |
| <input type="checkbox"/> | <input type="checkbox"/> | Tums (antacid)  |
| <input type="checkbox"/> | <input type="checkbox"/> | Cough Drops     |
| <input type="checkbox"/> | <input type="checkbox"/> | Orajel          |

**Note: If your child will be taking any other medication at school, you MUST contact the school nurse before medications can be given.**

I attest that this health history is accurate and complete. I am aware that throughout the course of the school year, my child *may* be screened for any and/or all of the following: height, weight, BMI (Body Mass Index), vision, hearing and blood pressure. I also understand that I may request further information regarding school screenings and my child's results, by contacting the school nurse.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name of Parent or Legal Guardian: \_\_\_\_\_

This is a confidential record for Health Office Use Only.  
Please return to the Health Office as soon as possible.