Cambridge Elementary School
Health/Emergency Form 2025-2026

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: _____

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:_____

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

YES / NO The school has my permission to contact my child's doctor.
YES / NO The school has my permission to contact my child's dentist.
YES / NO The school has my permission to contact my child's eye doctor.

Health Insurance

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

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

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.*

List any health conditions/diagnoses _____

_____

_____

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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.

Lamoille North schools will contact emergency services in the event of an emergency requiring their assistance.

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) Relationship to student Date