

EMERGENCY HEALTH INFORMATION FORM

Plainville Public Schools

Dear Parent or Guardian,

This information is requested annually so that the school nurse and parent/guardian can work together to meet your child's current health needs.

Please note: A physical exam is required for all new Preschool or Kindergarten students, as well as students entering Grade 1 and Grade 4. Please ask your healthcare provider for an updated physical exam form to submit to the school nurse. Thank you.

ANNUAL HEALTH HISTORY

Student Name: _____ Date of Birth: _____ Teacher _____

Please indicate if your child has any concerns in the areas below. If yes, please explain below.

	YES	NO
1. Allergies <i>Food, medication, environmental, or other allergies/reactions</i>		
2. Respiratory Conditions <i>Asthma or other breathing difficulties</i>		
3. Neurological / Developmental Conditions <i>ADHD, Autism Spectrum Disorder, Seizure disorder (epilepsy), other neurological conditions</i>		
4. Cardiac Conditions <i>Heart disease or heart-related concerns</i>		
5. Endocrine Conditions <i>Diabetes</i>		
6. Gastrointestinal / Urinary Conditions <i>Frequent stomach issues, Bowel or urinary concerns</i>		
7. Frequent or Recurrent Illness <i>Frequent colds, sore throats, or ear infections (4 or more per year)</i>		
8. Head, Vision, and Hearing <i>Frequent/severe headaches, Hearing or Vision impairment (glasses, contacts, colorblindness, etc.)</i>		
9. Musculoskeletal / Orthopedic Conditions <i>Orthopedic concerns, Scoliosis or back/spinal issues, History of significant injury</i>		
10. Skin Conditions <i>Eczema or frequent skin rashes</i>		
11. Mental Health / Behavioral Health <i>Anxiety, Depression, Eating disorder, Other psychosocial concern</i>		
12. Dietary Needs <i>Dietary restrictions or special dietary needs</i>		
13. Hospitalizations / Significant Medical Events <i>Accidents (concussions) or hospitalizations (please specify)</i>		
14. Other Medical Conditions- <i>other chronic or significant health concerns not listed above</i>		

***Please provide details for any items marked above:**

OVER



Student Name: _____

*****IMPORTANT - PLEASE COMPLETE!*****

Log onto SNAP Health Portal www.studentehr.com
to select OTC medication to be provided in school

☐ Check Box if completed

Over-the-Counter Medications at School:

The following over-the-counter medications may be given at school as needed, with parent/guardian consent and per the Plainville Public Schools physician order. Please complete this form and the online portion. This paper copy will be used as a backup if the electronic system is not available.

Please check if the following medications may be administered at school as needed (parent/guardian consent):

Medication Name:	Yes	No	Medication Name:	Yes	No
Acetaminophen/Tylenol			Cetirizine HCl (antihistamine)		
Alcohol prep pads (cleaning skin)			Benadryl/Diphenhydramine (hives/rash)		
Aloe Vera (skin conditions/sunburns)			First Aid Burn cream (skin)		
Antacid tablets (acid indigestion)			Hydrocortisone cream (skin)		
Antibiotic ointment (for cuts/abrasions)			Ibuprofen/Motrin		
Antihistamine eye drops (for allergies)			Lubricant eye drops (dryness/irritation)		
Antiseptic solution (to clean cuts)			Petroleum jelly (moisturize/protect skin)		
Aquaphor/skin lotion (skin conditions)			Sunscreen (protect skin)		
Caladryl lotion (for bug bites, poison ivy)			Throat lozenges/cough drops		

Current Prescribed Medications/Supplements:

	Medication Name	Dosage	Time given	Reason for medication
1				
2				
3				

These medications require a separate doctor's order and parent consent if needed in school.

- In case of accident or serious illness the school will contact the parent/guardian. If the school is unable to reach parent/guardian the school will initiate the emergency response plan.
- Health information may be disclosed to school, medical, or other professional personnel on a need-to-know basis, in accordance with the Family Educational Rights and Privacy Act (FERPA).

Field Trip Consent: I authorize the school nurse to delegate the administration of my child's medication, currently stored at school, to a designated school staff member for use during field trips.

YES ☐ NO ☐

Signature of parent or guardian: _____ **Date:** _____

Cell Phone: _____ Work Phone: _____

Has your child been to the dentist in the last 12 months? YES ☐ NO ☐

Dentist: _____ Phone: _____

Physician: _____ Phone: _____

Health Insurance: ☐ Public ☐ Private Health Insurance Carrier: _____