



Annual Health form and Information 2026/2027

Student Name	
Date of Birth	
Grade	
Physicians Name and Number	

Does your student have any allergies? Please indicate below yes or no.
If yes, do they require an EpiPen/Auvi-Q- please explain symptoms/ reactions.

Does your student have any chronic medical conditions (diabetics, seizure disorder or history of seizures, asthma, etc.) Please indicate below yes or no. If yes, please explain.

▲ NOTE ON LIFE-THREATENING CONDITIONS: If your child has a life-threatening allergy (LTA), asthma, diabetes, or a seizure disorder, an **Action/Safety Plan** signed by both a physician and a parent/guardian must be submitted to the health office.

Does your child take any prescribed medication on a regular basis at home? If yes, specify medication name and reason: If medication needs to be administered during the school day please coordinate with the school nurse immediately.

Additional Notes: Please add any further information necessary to facilitate the health and well-being of your child:

Please turn page over and continue filling out

School Nurse Medication Permission

The following over-the-counter medications can be administered as needed during school hours by the school nurse per school physician orders.

Please check **YES** or **NO** for each individual medication to grant permission: I give permission for the following administer the following:

Acetaminophen (Tylenol)	☐ yes	☐ no
Ibuprofen (Motrin/Advil)	☐ yes	☐ no
Benadryl (Diphenhydramine)	☐ yes	☐ no
Tums (Calcium Carbonate)	☐ yes	☐ no
Cough drops	☐ yes	☐ no
Hydrocortisone cream/anti-itch	☐ yes	☐ no
Antibiotic Ointment	☐ yes	☐ no
Orjel	☐ yes	☐ no
Burn cream/gel	☐ yes	☐ no

Disclosures, Authorizations & Signatures

- I hereby authorize the school to call my student's physician if I cannot be reached and such a call is considered necessary. By signing below, you grant permission for the health information contained on this form to be accessible to the following on a need-to-know basis: School nurse, your child's teacher, office personnel, administrative personnel and party responsible for health room coverage, and emergency medical personnel.

Parent/Guardian Signature: _____ Date: _____

School Nurse Contact Information

Ashley Allard, RN BSN
Hoosac Valley Elementary School grades pk-3
District Nurse Leader
aallard@hoosacvalley.org 413-743-0876

Cassidy Brewer, RN BSN
Hoosac Valley Middle & High School grades 4-12
cbrewer@hoosacvalley.org 413-743-5200

HVRSD NURSES FAX LINE: 413-749-7253