Waits River Valley School Health Information Form

Student_____DOB_____
Grade _____ Teacher_____

Doctor's Name and Phone Number _____
Dentist's Name and Phone Number _____

Has your child had a physical in the last twelve months?		Yes	No
Has your child had a dental exam in the last twelve months?		Yes	No
WRVS is working with The Health Center in Plainfield, VT to return the Dental Van to our school to help with dental services for children without current dental homes. Would you like more information about upcoming programming? **Scheduled to be at WRVS week of 9/14/26**		Yes	No
WRVS is working with Little Rivers Health Care to provide school based health care. Would you consider having your child (ren) evaluated at school similar to an urgent care visit? If yes, more information will be sent home with your child about this program.		Yes	No
Has a health professional ever said your child has asthma?	Yes	No	Not sure
If yes, does your child still have asthma?	Yes	No	Not sure
Does your child have health insurance?		Yes	No

Does your child have any health problems, illnesses, or disabilities that we should know about?

_____
_____

Please explain how the condition should be managed at school (if a care plan not already in place):

_____
_____

Please list all of the child's medications:

_____
_____

Does your child have any allergies? What happens when your child is exposed to these things?

_____
_____

(See Reverse Side)

Do you give permission for the school nurse or designee to administer an age/weight appropriate dose of the following (please initial):

Tylenol/Acetaminophen _____	Bacitracin Ointment _____
Advil/Motrin/Ibuprofen _____	Hydrocortisone 1% Cream _____
Benadryl/Diphenhydramine_____	Calamine Lotion _____
Cough Drop _____	Tums _____

In case of an accident or illness, I request the school to contact me. If not able to reach me or my emergency contact listed, I hereby authorize the school personnel to administer basic first aid and seek emergency medical care if appropriate, including notifying my child's doctor and transportation to the emergency room. I hereby authorize the administration of emergency treatment necessary at my expense.

NOTE: FOR THE SCHOOL NURSE TO ADMINISTER PRESCRIPTION MEDICATION, THE PHYSICIAN MUST FAX AN ORDER TO THE SCHOOL AND MEDICATIONS MUST BE IN THE LABELED PHARMACY CONTAINERS. PLEASE CONTACT SCHOOL NURSE FOR PRESCRIPTION MEDICATIONS OR MEDICATIONS NOT ON THIS LIST.

Parent Signature _____

Date_____

Release of Medical Information:

I understand that the school nurse may occasionally need to contact my child's PCP/dentist/optometrist/specialist regarding immunizations, medications, appointment dates, allergies, vision, or other significant health issues. I grant permission for my child's healthcare provider and the school nurse to exchange educationally pertinent medical information which they deem to be in the best interest of my child. I acknowledge that I understand the purpose of this request and that authorization is hereby granted voluntarily. I further understand that I may change or revoke this authorization at any time in writing.

Student Name (printed) _____

Parent Signature _____

Date_____