GRAND ISLE SUPERVISORY UNION

ANNUAL HEALTH UPDATE & EMERGENCY AUTHORIZATION FORM for year: 2020/2021

Student: Last First Middle

Date of Birth: _____ Grade: _____

School (select): Alburgh Folsom Grand Isle North Hero

Does your child have health insurance? **YES ___ NO ___**	
Doctor's Name:	Phone:
What was the date of your child's last annual well care visit*****? **Date**: _____	
Dentist's Name:	Phone:
What was the date of your child's last dental exam? **Date**: _____	

***An annual well care visit <u>is not</u> a sick appointment. An annual well care visit is recommended by the American Academy of Pediatrics for all school aged children.**

STUDENT'S MEDICAL HISTORY:

1. Has a **doctor, nurse, or other health professional** <u>EVER</u> said that your child has **asthma**?
   - **YES**
   - **NO**
   - **Don't know/Not sure**

2. If yes, does your child <u>STILL</u> have **asthma**?
   - **YES (** If yes, please request an <u>updated</u> Asthma Action Plan from your child's health care provider.)**
   - **NO**
   - **Don't know/Not sure**

3. Does your child have **diabetes**? **YES ___ NO ___**
4. Does your child have **seizures**? **YES ___ NO ___**
5. Does your child have an **allergic reaction** from any of the following:
   - Outside or indoor allergens (example: grass, pollen, dust…) **Please list below.**
   - Foods (example: nuts, wheat, milk….) **Please list below.**
   - Insect or animal allergies (example: bees, dogs….) **Please list below.**
   - Medicines or shots (immunizations). **Please list below.**
   - **NO,** my child does not have allergies (that I am aware of).

My child is allergic to:	**This happens when my child has a reaction:**

6. **Does your child REQUIRE an EPIPEN for ALLERGIC REACTIONS? YES ___ NO ___**

7. Are there any other health concerns or conditions that the health office should be aware of? (ex. color blind, anxiety, kidney issues, etc) **YES ___ NO ___**
   - **If yes, please explain:**

     _____

8. Does your child wear glasses or contact lenses? **YES ___ NO ___,** Hearing aids? **YES ___ NO ___**

****MEDICATION POLICY REMINDER: Any prescription medication will only be given with a doctor's order and parental permission. Children are not to bring medications in to school. We request that parents bring in all medications (prescription and non-prescription) *in their original container, with appropriate labels,* to the health office directly. ****

9. Is your child taking any **prescription medicines?**
    - **NO, my child does not take any prescription medicines. (If no, skip to question #10)**
    - **YES (If yes, please list medications below)**

Name of medicine:	**Amount/Dose:**	**How many pills does your child take:**
Example: Focalin XR	20 mg	1 pill in morning, 1 pill in evening

10. What **over-the-counter medicines** does your child take **regularly**?
    - Vitamins
    - Herbal medicines (please list):_____
    - Other medicines (please list)_____
    - **NONE, my child does not take over- the-counter medicines regularly**.

I give permission for health office staff to administer the following medications at school as needed, and as directed on the label:
Acetaminophen (Tylenol): YES ___ NO ___
Ibuprofen (Advil/Motrin): YES ___ NO ___
Benadryl: YES___NO____
The school health office staff may use over the counter medications (e.g. antibiotic ointment, anti-itch cream, calamine lotion, honey or cough drops) at their discretion. If you have objections to the use of these medications on your child, please contact the health office.

11. School personnel who are responsible for my child may apply or assist with the application of products supplied by me (the parent/guardian) according to the written manufacturer's label for children.

    SUNSCREEN: YES ___ NO ___ **INSECT REPELLENT:** YES ___ NO ___

IN CASE OF AN EMERGENCY INVOLVING MY CHILD, WHEN I CAN NOT BE REACHED: I hereby give consent to transport my child for medical care and authorize the providers and hospital to give any reasonable and customary medical and health care deemed necessary at my expense. It is understood that I will be financially responsible for all emergency care.

I give permission to exchange health information between my child's primary care provider and the School Nurse or Health Assistant, including vision and hearing screening information: ____ Yes ____No

Signature of Parent/Guardian: _____

Relationship to student: _____ Date: _____