MSAD#52 ANNUAL HEALTH UPDATE

Student Name:_____ DOB_____ Grade/Teacher_____
Student's Physician_____ Physician's Phone_____
Father:_____ Mother:_____ Resides with::_____
Hospital of Preference: _____

Dear Parent/Guardian,
The medical /health forms are kept confidential and will help the school personnel to meet the needs of your child. Medical records are kept in the health office. Please remember to review the reverse side of this document, sign and return to the school.

Please List:

1. Please check if your child has had difficulty with any of the following. Please give dates and additional information in the comments. Please contact your school nurse with questions and concerns.

- ❑ ADD/ADHD
- ❑ Allergy: Bee Sting(check below)
  Mild___ Moderate___Severe___
- ❑ Allergy: Food (list below)
  Mild___Moderate___Severe___
- ❑ Allergy: Medication (list below)
- ❑ Allergy:Unknown causes
- ❑ Asthma (check below)
  Mild___Moderate___Severe___
- ❑ Birth defect/Chromosomal disorder
- ❑ Blood disorder
- ❑ Cancer (note diagnosis below)
- ❑ Cerebral Palsy
- ❑ Color blindness
- ❑ Cystic Fibrosis
- ❑ Depression
- ❑ Diabetes
- ❑ Ear/hearing problems (please explain)
- ❑ Epilepsy/seizure history

___Eye/ Vision problems
___Heart Disease/Defect
___Hemophelia
___Hyperactive
___Juvenile Rheumatoid Arthritis
___Kidney disorder (explain below)
___Medication prescribed (explain below)
___Medication needed at school
(form must be filled out and Doctor order)
___Muscular Dystrophy
___Migraine Headaches
___Physical activity limitations (requires PCP note)
___Prone to headaches
___Prone to nose bleeds (check one)
Mild___Moderate___Severe___
___Rheumatic Fever history
___Other (please explain)
___**NO KNOWN HEALTH PROBLEMS**

Comments:_____
_____

2. Illnesses, hospitalizations or treatments by a physician in the last year.
_____

3. Any physical or emotional restrictions that your child may have will require a doctor's note:_____

4. Medication(s), the dosage, the time of day and the reason that your child takes the medication._____

5. If your child uses an inhaler or EpiPen, we must have a doctor's note stating that the child has a medical reason to carry the inhaler or EpiPen. Please include a copy of the child's Asthma Action Plan/Food Allergy Action Plan /or Physician's note.

Continued on the back of this paper. Please complete, date, sign and return to the school.

Please list ALLERGIES and INTOLERANCES below: (MUST INCLUDE A DOCTOR'S NOTE)

Foods_____ Medicine_____

Environmental_____ Bee Stings/ Insect _____

Latex_____ Other:_____

Additional Information or Concerns:_____

All medications in bold print must be provided by the parent. Return this form to the health office.

Medication	**Usage**
Tylenol/ Acetaminophen	Every 4 hours for fever or discomfort Student will go home with a fever
Advil/Motrin/ Ibuprofen	Every 6 hours for fever or discomfort Student will go home with a fever
Benadryl	Every 6 hours as needed for itching (hives/allergic reaction)
EpiPen, Jr 0.15mg or EpiPen 0.3 mg	For a severe allergic reaction with breathing difficulty. (anaphylactic reaction)
Cough drops	For minor cough, sore throat
Tums/Rolaids/ mints	For minor gastric upset or minor heartburn
Hydrogen Peroxide Bacitracin Anti itch lotion Hydrocortisone cream 1%	Basic first aid
Petroleum jelly	For dried or irritated skin
Aloe Vera Gel	For minor sun burns, or chafed skin
Hand lotion	Irritation or dry skin
Artificial tears	For rinsing eyes/contacts
Salt	Warm salt gargles for sore throats and basic first aid
Baking soda paste	Insect and bee sting salve

I understand that the parent/guardian is responsible for transporting and providing the above mentioned **medications**. In the event of an unknown anaphylactic reaction, the emergency medications will be administered, the parent will be contacted and the student will be transported via ambulance to the hospital. I understand that school employees are not medically trained personnel and that the school nurse may not always be available to dispense the above medication/treatments. With full knowledge of this, I hereby give permission for the administration for the above medication/treatments by the school nurse or other non-medical school personnel designated by the school principal.

Student Name:_____

Parent/Guardian Signature:_____ **Date:**_____

Updated 3/18