

**COLCHESTER SCHOOL DISTRICT**

**STUDENT HEALTH INFORMATION UPDATE FORM**

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Allergies: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Last Physical Exam: \_\_\_\_\_

Current Health Problems: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Name of Medication	Dose	Time Given
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Name of Medication	Dose	Time Given
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Date of Recent Immunizations: DPT/TD \_\_\_\_\_ Polio \_\_\_\_\_ MMR \_\_\_\_\_

Hepatitis B: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Last Exam: \_\_\_\_\_

Current Dental Problems: \_\_\_\_\_

Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

**PERMISSION FOR RELEASE OF INFORMATION**

I authorize the school nurse to contact the above physician, when appropriate, for a 2-way exchange of medical information. I understand that I will be contacted prior to this communication.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PERMISSION FOR TREATMENT**

In the event of a serious accident or illness, I hereby authorize the school to contact my child's physician and/or to seek emergency medical care including transportation to a medical facility. I hereby authorize the physician and emergency room staff to administer care that is deemed necessary. I understand every effort will be made to contact family first.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PERMISSION FOR OVER THE COUNTER MEDICATIONS**

My child has permission to receive the following medications at school:

- |   |                           |
|---|---------------------------|
| _____ Acetaminophen (Tylenol)                       | _____ Ibuprofen (Advil)   |
| _____ Benadryl (for allergic reactions)             | _____ TUMS/Antacid        |
| _____ Calamine Lotion (for insect bites)            | _____ Cough Drops         |
| _____ Hydrocortisone Cream (for Contact Dermatitis) | _____ Antibiotic ointment |

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_