

**COLCHESTER SCHOOL DISTRICT  
STUDENT HEALTH INFORMATION UPDATE FORM**

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Allergies: \_\_\_\_\_

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

**Health Problems that have resolved or are discontinued:** \_\_\_\_\_

**Current Medications:**

Name of Medication	Dose	Time Given
--------------------	------	------------

(use separate page if needed)

Name of Medication	Dose	Time Given
--------------------	------	------------

Name of Medication	Dose	Time Given
--------------------	------	------------

**Any Recent Immunizations?** No \_\_\_\_\_ Yes: \_\_\_\_\_ Please list: \_\_\_\_\_

PERMISSION FOR RELEASE OF INFORMATION

I authorize the school nurse/school health team to contact the physician listed below, 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 MEDICATION

The following items are available in the health office. Please check off those items you will ALLOW your child to have during the course of routine visits to the health office and sign below.

- |                               |   |
|-------------------------------|---|
| _____ Acetaminophen (Tylenol) | _____ Calamine Lotion                     |
| _____ Ibuprofen (Advil)       | _____ Hydrocortisone Cream 1% (anti-itch) |
| _____ Antacid Tablets (Tums)  | _____ Bactine First Aid Cream             |
| _____ Benadryl                |   |

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

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

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

**Health Insurance Coverage (please circle one of the following):**

Blue Cross      MVP      Cigna      Medicaid      Other \_\_\_\_\_      None

## ANNUAL MEDICAL UPDATE

Please take a moment to answer the following questions about your child's health. Please remember to update our office if any changes to medications or conditions occur during the school year. (Reminder: All prescription medications needed at school MUST be brought to school by an adult in a pharmacy labeled container with a separate physician authorization updated each school year.)

1. Does your child have asthma or other airway disease? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please answer the following:

A. Which statement best describes your child's asthma?

Currently active \_\_\_\_\_ Medication prior to exercise \_\_\_\_\_ Rare/occasional issues \_\_\_\_\_ Resolved \_\_\_\_\_

B. What are your child's typical triggers?

Exercise \_\_\_\_\_ Illness \_\_\_\_\_ Allergies \_\_\_\_\_ Cold weather \_\_\_\_\_

C. Does your child understand their asthma and its management? Yes \_\_\_\_\_ No \_\_\_\_\_

D. How would you like the school to manage the asthma should the need arise at school?

2. Does your child have a severe allergy? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please answer the following:

A. What are your child's allergens? \_\_\_\_\_

B. Does your child require an Epi Pen? Yes \_\_\_\_\_ No \_\_\_\_\_ (if yes please provide MD order & medication)

C. How should we manage the allergen at school? \_\_\_\_\_

3. Has your child experienced any of the following? If yes, please explain.

	No	Yes		No	Yes
Seizures?	_____	_____	Illness lasting longer than 1 week?	_____	_____
Blow to head or unconsciousness?	_____	_____	Operations or hospitalizations?	_____	_____
Dizzy or fainting episodes?	_____	_____	Vision concerns?	_____	_____
Sprain or fracture?	_____	_____	Hearing concerns?	_____	_____
Any other injury?	_____	_____			

EXPLAIN ANY YES ANSWERS: \_\_\_\_\_

\_\_\_\_\_

