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)
_____ Ibuprofen (Advil)
_____ Antacid Tablets (Tums)
_____ Benadryl
_____ Calamine Lotion
_____ Honey (1 tsp) for cough
_____ Hydrocortisone Cream 1% (anti-itch)
_____ Bactine First Aid Cream

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

OVER ➔

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: _____

_____