WINNISQUAM REGIONAL SCHOOL DISTRICT
ANNUAL HEALTH INFORMATION UPDATE

BOTH SIDES TO BE COMPLETED BY PARENT/GUARDIAN AND RETURNED TO THE SCHOOL NURSE.

Student's Name Date of Birth Grade **Does the student currently have or has had in the past year any of the following conditions?**

Condition **YES**		**NO**
Allergy		
ADHD/ADD		
Anemia		
Asthma		
Back/Neck Injury		
Bladder/Kidney Disease		
Convulsions/Seizures		
Diabetes		
Head Injury/Concussion		
Headaches (frequent)		

Mononucleosis		
Orthopedic/Bone injury		
Psychological/Psychiatric		
Respiratory condition other than asthma		
Surgery		
Other (explain below)		

Please give details and dates on all of the above marked **YES**

Is your child taking any **medication** on a regular basis (prescription or non-prescription)? List the medication, dose, time, and reasons for taking.

Condition **YES NO**		
Hearing Loss/Hearing Aide		
Heart Condition/irregular heartbeat		
Hepatitis		
High blood pressure		

NO YES.

*** If your child needs to take prescribed medication during the school day, please see the school nurse for additional paperwork. Please review our medication Policy in the Student Handbook.**

If your child has received immunizations since last reporting to school **please provide a copy of the current immunization record from your primary care provider.**
Primary Care Provider Phone
Dentist Phone

Does your child have health insurance? NO YES. Health Insurance Company
Policy/Group # Subscriber

I request that the school call me if my child is injured or becomes ill. If they are unable to reach me, I authorize the school to call emergency contacts on file with the school. I understand that the school will call 911, as deemed necessary by school officials. I authorize the school to contact the physician/PCP listed above for the purposes of consultation and direction when my child is sick or injured as well as obtain medical information regarding immunizations, medication/treatment orders and physical exams. I also allow the school nurse to share health information with other school personnel working with my child if relevant. The school may make whatever arrangements seem necessary, including epinephrine for life threatening anaphylaxis (severe allergic reaction). I authorize the hospital staff to provide medical care to my child. I understand that any and all expenses incurred for emergency transportation and medical care of my child are my responsibility and not that of the Winnisquam Regional School District.

Signature of Parent/Guardian_ Date **PLEASE COMPLETE BACK SIDE OF FORM**

WINNISQUAM REGIONAL HIGH SCHOOL
OVER THE COUNTER MEDICATIONS
PARENTAUTHORIZATION

By checking the medications below, I give permission for my child to receive the following during the school year. I will hold harmless any member of the school staff designated to give this non-prescribed medication. Please check off doses that you are giving authorization to.

Diphenhydramine: (Benadryl) for allergic reactions
Acetaminophen: (Tylenol) for headache, fever, minor pain: 325 mg____ or 650 mg_____ Ibuprofen (Advil, Motrin) for headache, fever, minor pain: 200 mg____ or 400mg____ Antacid tabs (Tums) for acid reflux and upset stomach
Bismuth subsalicylate (Pepto Bismol) for upset stomach, diarrhea
Phenylephrine hydrochloride: (non-drowsy Sudafed) for congestion: 10mg_____
Refresh eye drops
Calagel lotion for skin rashes such as poison ivy
Anbesol- for mouth or dental pain

Please do not give any medications without a phone call to me first.

Please notify me if my child comes frequently to the nurse's office

I understand it will be my responsibility to notify the School Nurse should there be a change in the medical status or allergies for my child.

Signed _____ Date_____
Parent or Legal Guardian

Revised 6/20/18