MSAD 11
Health History / Annual Update

Student Name_____ Birth Date_____ Grade_____

Physician_____ Physician Phone _____

Does your child wear glasses/contact lenses? Yes No Hearing aids? Yes No
Does your child have any allergies? Yes No Is the allergy life threatening? Yes No
If yes, is there an epipen prescribed? Yes No

Please describe your child's allergies:

Food _____ Medication _____

Insect stings _____ Other_____

Please list any prescription medication your child takes. Include dose and time taken. _____

_____

Please list any chronic health problems your child has had diagnosed by a physician. (ex. asthma, diabetes, seizure disorder) _____

_____

Please list any hospitalization, surgery, major illness or injury your child has had in the past year._____

Please call the school nurse with any health needs including allergies,chronic conditions, and medications that require attention at school in order to make a plan of care for your child.

If you wish to grant permission for **ONLY** the school nurse to administer the following medication (on an as needed basis) to your child, please **initial** the spaces below:

Acetaminophen for minor pain ____ Ibuprofen for minor pain ____
Hydrocortisone for minor skin rashes ____ Antibiotic ointment for skin abrasions ____
Benadryl for minor allergic reaction ____ Antacid for Heartburn ____
(The school nurse will attempt to contact parent when giving any as needed medication)

Medical Release of Information
I give permission for release of medical information for confidential use in meeting my child's health and educational needs in school.
☐ Please check here if you do not wish to release medical information to the school nurse

Signature of Parent/Guardian _____ Date _____