updated 11/2024

Caledonia Central Supervisory Union

Cabot School, Twinfield School,
Danville School District, Peacham School District
Caledonia Cooperative School District (Barnet, Walden & Waterford Schools)

ANNUAL HEALTH UPDATE & EMERGENCY AUTHORIZATION FORM

PURPOSE: To enable parents/caregivers to AUTHORIZE emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached. Parents/ caregivers must return this form to the school. The original form and any copies may be used to identify the medical options of the undersigned parent/caregiver. The original form stays with the school nurse.

Student's Full Name

_____

Last **First** **Middle initial** **(He, Her, They)**

_____ _____ _____ _____

Home Room Teacher **Grade** **Date of Birth** **School Year**

Parent/Guardian's Name_____ Employer_____

TE #: (H)_____(C)_____(W) _____ email:_____

Parent/Guardian's Name_____ Employer_____

TE#: (H) _____(C)_____(W)_____ email_____

Doctor's Name:	**Phone**
Has your child had a comprehensive annual well care visit* received in their medical home in the past year? Date: _____	
Dentist's Name:	**Phone**
Has your child had a dental exam received in their dental home in the past year? Date: _____	

*** Comprehensive well care visit is not an exam for a specific injury, illness, condition, or sports clearance form completion.**

STUDENT'S MEDICAL HISTORY:

- **ALLERGIES: Serious- Requires epinephrine: (please describe)_____**

_____

- **ASTHMA:** Has a doctor, nurse, or other health professional EVER said that your child has asthma?
  _____ Yes _____ No _____ Don't know/not sure
  - **If yes**, does your child STILL have asthma?
  _____ Yes _____ No _____ Don't know/not sure
- **DIABETES? Yes ____ NO _____ SEIZURES? Yes ____ NO _____**
- **OTHER CHRONIC HEALTH CONDITIONS:_____**

_____

- **MEDICATIONS taken on a regular basis (Please explain): _____**
  Taken at Home:_____Needed at school:_____

- **USE CORRECTIVE LENSES? YES_____ NO _____ HEARING AIDS? YES _____ NO _____**

Eye Doctor:_____ Date of last eye exam:_____

Does your child have health insurance? Yes ___No ___Dental Insurance: Yes__NO___ If No, **dial 1-855-899-9600** for Vermont Health Connect info [https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action]

IN CASE OF AN EMERGENCY INVOLVING MY CHILD, WHEN I CAN NOT BE REACHED: I hereby give consent to transport my child for medical care and authorize the providers and hospital to give any reasonable and customary medical and health care deemed necessary at my expense. It is understood that I will be financially responsible for all emergency care.
Signature of Parent/Guardian _____ Date _____

*I give my permission for the school nurse or **802Smiles/tooth tutor** (if available) to communicate with my dental provider:* **Yes No**
I give permission for the school nurse to give and receive health information to/from my child's:
__Primary care Provider __Eye doctor __Dentist __Counselor __Mental health provider __Drug and Alcohol treatment __Other:_____
Signature of Parent/Guardian _____ Date _____

Please indicate if student has had or is currently under treatment for any of the following conditions:

_____BLEEDING DISORDERS _____
_____EAR/HEARING PROBLEMS _____
_____HEART PROBLEMS_____
_____HIGH BLOOD PRESSURE_____
_____HOSPITALIZED FOR SERIOUS ILLNESS, SURGERY OR ACCIDENTS? _____
_____OTHER allergies: (Please list) _____ _____

_____ MENTAL HEALTH CONDITION and treatment (Please explain):
_____
_____
_____MUSCULAR WEAKNESS OR PARALYSIS
_____MIGRAINE HEADACHES

Any specific concerns about the health and wellbeing of your child? (check all that apply and please describe)
____Emotional or behavioral health:_____
____Growth and Development:_____
____Physical health:_____
____Oral health:_____
____Nutrition:_____
____Other:_____

Authorization for Over-The Counter Medication
Permission to receive over the counter medication under the judgment and supervision of the school nurse or nurse designee. Please check all that apply
___Acetaminophen ___Ibuprofen ___cough drop ___Benadryl ___Zyrtec(cetirizine)
___Triple antibiotic ointment/bacitracin ___hydrocortisone cream ___Calamine lotion ___Ora-gel
__Tums

School personnel who are responsible for my child may apply or assist with the application of products supplied by me (the parent/guardian) according to the written manufacturer's label for children.
SUNSCREEN: YES ___ NO ___ **INSECT REPELLENT:** YES ___ NO ___

_____ _____ _____
Signature – Parent or Guardian **Relationship to student** **Date**