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.

| Last | First | t | Middle init | ial | (He, Her, They |
|---|----------------|----------------|------------------|------------|-------------------------------|
| Home Room Teacher | - | Grade | Date of Bir | th S | chool Year |
| Parent/Guardian's Name_ | | | | Employer_ | |
| TE #: (H) | _(C) | (W) | email: | | |
| Parent/Guardian's Name_ | | | E | mployer | |
| TE#: (H) | _(C) | (W) | email | | |
| Doctor's Name: | | | | Phone | |
| | comprehensi | ve annual well | | | r medical home in the past |
| Dentist's Name: | | | | Phone | |
| Has your child had a Date: | | | | · | |
| STUDENT'S MEDICAL H ALLERGIES: Serious | ISTORY: | · | | • | ts clearance form completion. |
| • ASTHMA: Has a do | ctor, nurse, o | r other health | professional EVE | R said tha | t your child has asthma? |
| Yes | No | Do | n't know/not sur | re e | |
| o If yes , does | your child ST | TLL have asthm | na? | | |
| Yes | No | Do | n't know/not sur | e | |
| | NO | SEIZURES? | Yes NO | | |
| | | | | | |
| DIABETES? Yes | | | | | |
| • DIABETES? Yes | EALTH COND | ITIONS: | | | |

| updated 11/2024 ■ USE CORRECTIVE LENSES? YES NO | HEARING AIDS? YES NO |
|---|---|
| Eye Doctor: Date of la | ast eye exam: |
| Does your child have health insurance? YesNo855-899-9600 for Vermont Health Connect info [https://portal.healthconnect.vermont.gov/VTHBELa | |
| IN CASE OF AN EMERGENCY INVOLVING MY CHILD, consent to transport my child for medical care and a reasonable and customary medical and health care that I will be financially responsible for all emergence Signature of Parent/Guardian | uthorize the providers and hospital to give any deemed necessary at my expense. It is understood y care. |
| I give my permission for the school nurse or 802Smill dental provider: Yes No I give permission for the school nurse to give and recomprise care ProviderEye doctorDentist _ Alcohol treatmentOther: Signature of Parent/Guardian | _CounselorMental health providerDrug and |
| Please indicate if student has had or is currently undBLEEDING DISORDERSEAR/HEARING PROBLEMS HEART PROBLEMS | ler treatment for any of the following conditions: MENTAL HEALTH CONDITION and treatment (Please explain): |
| HIGH BLOOD PRESSURE HOSPITALIZED FOR SERIOUS ILLNESS, SURGERY OR ACCIDENTS? OTHER allergies: (Please list) | MUSCULAR WEAKNESS OR PARALYSISMIGRAINE HEADACHES |
| Any specific concerns about the health and wellbeing of the specific concerns about the health and wellbeing of the specific concerns about the health and wellbeing of the specific concerns about the health: | |
| Authorization for Over-The Counter Medication Permission to receive over the counter medication undourse designee. Please check all that apply AcetaminophenIbuprofencough drop Triple antibiotic ointment/bacitracinhydrocTums | BenadrylZyrtec(cetirizine) |
| _ | |

Relationship to student

Date

Signature – Parent or Guardian