Medical History Form for Newly Enrolled Students **Date:_____/_____/_____**
MRUUSD Elementary Schools, circle one: CES, SMS, TES, WES

Student's Legal Name:_____ Date of birth:_____

Student's preferred name:_____ Grade:_____

MEDICAL HISTORY:	
Chicken Pox Date if had chickenpox: _____	Yes No
Head Injury or Concussion	Yes No
Ear infections *(frequent or ear tubes, etc.)*	Yes No
Nose problems *(sinus infections, nose bleeds)*	Yes No
Eye or Vision problems *(blurry vision, wears glasses, lazy eye)*	Yes No
Hearing problems *(has trouble sometimes, wears hearing aid)*	Yes No
Tooth, Mouth or Throat problems *(Strep throat, swallowing issue, dental surgery, braces)*	Yes No
Stomach problems *(indigestion, pain)*	Yes No
Bowel problems *(constipation, fecal soiling, gas)*	Yes No
Urine problems *(bed wetting; pain when peeing; accidents)*	Yes No
Back problems *(crooked back, back pain)*	Yes No
Muscle and bone problems *(weak muscles, pain in joints, past injuries)*	Yes No
Skin problems *(acne, flaking skin, rashes, hives, eczema)*	Yes No
Seizures *(shaking fits or convulsions)*	Yes No
ADHD *(problems paying attention, sitting still)*	Yes No
Breathing problems *(cough, asthma, bronchitis, pneumonia)*	Yes No
Heart problems *(fast or irregular heartbeat, murmur, birth defect)*	Yes No
Emotional or mood problems (*depression, anxiety, fears)*	Yes No
Seasonal or environmental allergies	Yes No
Medication allergy:	
Food allergy	
Other:	
Comments / Description:	

For any problems circled with a yes please be prepared to provide medical documentation.

Student's Name:_____ **Date of birth:**_____

BIRTH HISTORY:
How many weeks gestation was your child born? _____
Birth weight: _____pounds _____ ounces
Were there any complications?

ALLERGIES:	Daily medication, if any	Emergency medication, if any
Medication allergies:		
Food allergies:		
Seasonal allergies:		
Environmental allergies:		
Other:		

HOSPITALIZATIONS OR SURGERIES:		
Reason for hospitalization -or- Type of surgery	Date if known -or- Age at the time	Hospital or clinic name

Does your child have health insurance coverage? **Yes** **No**
For information about Vermont's medicaid for children program, Dr.Dynasaur, call (800)250-8427 or go to: https://info.healthconnect.vermont.gov/compare-plans/medicaid-and-dr-dynasaur

Student's Name:_____ **Date of birth:**_____

MEDICATION: **Please include prescriptions and over-the-counter or herbal medicines, even if they are not taken every day.**			
Name of medication	Dosage	When is this medicine given?	If this is a prescription, please list the provider

HEALTH ACCESS:			
Primary Care Provider:	Date of last Wellness Exam: ____/____/____	Phone:	School Health Office May Contact: **Yes No**
Dental Care Provider:	Date of last Wellness Exam: ____/____/____	Phone:	School Health Office May Contact: **Yes No**
Other Specialists: (Attach additional list if necessary)	Date of last appointment: ____/____/____	Phone:	School Health Office May Contact: **Yes No**

FAMILY CONTACT INFORMATION:			
Parent, guardian, or family member name	**Relationship**	**Preferred daytime phone**	**Secondary phone**

Student Name: _____ Date of Birth: _____ Grade: _____

Please list any prescription or over-the-counter medications taken. Include dosage, frequency and prescribers name if applicable:

_____

_____

_____

Will any prescription medications need to be given at school? Yes No

If so, please contact the health office as soon as possible to discuss and note the following details:

- Prescriptions must be delivered in the original pharmacy container.
- A signed provider order with permission to administer at school is required.
- All medication must be stored in the health office.
- Morning medications should be administered at home prior to arrival.
- The school will not administer the first dose of a new medication.

Over-the-Counter (OTC) Medication Permission I hereby give my permission for my student to receive the over-the-counter medications as listed, or the generic equivalents, as needed and if available, per package instructions. Please draw a line through anything that is specifically not approved.	• Acetaminophen (Tylenol) • Ibuprofen (Advil) • Diphenhydramine (Benadryl) • Cough drops • Caladryl or Calamine • Antibiotic ointment or First Aid Cream • Saline eye wash • Aloe or Burn gel • Unscented lotion (Eucerin or Lubriderm) • Vaseline or Lip Balm • Sunscreen
Parent/ Guardian Signature: _____ Date: _____	

Other OTC Medications: Please note, if you would like to send in over-the-counter medication for your child to be stored in the school health office as needed, please speak with the health office staff to complete a permission form. All medication must be delivered in a new, unopened package.

Parent/ Guardian Authorization for Treatment

I give consent to the school RN, LPN, or medical designee to provide the over-the-counter medications listed above, prescription medications on file, and first aid treatment per school district protocol.

In case of an emergency, I hereby give consent for school personnel to seek emergency medical or dental care, including transportation via ambulance to the emergency room at my expense. I request the school contact me or one of my designated emergency contacts as soon as possible following initiation of emergency treatment. If I am not reachable, I authorize the emergency providers and hospital to give any emergency treatment deemed necessary. It is understood that I will be financially responsible for all emergency care.

Parent/ Guardian Printed Name:_____

Parent/ Guardian Signature:_____ Date:_____