Washington West Supervisory Union

ANNUAL STUDENT HEALTH QUESTIONNAIRE

PART 1 PARENT OR GUARDIAN TO COMPLETE. Parent or guardian is encouraged to participate in the development of an Individual Healthcare Plan if needed.

STUDENT: Last	First	Middle	Sex ☐ M ☐ F	Grade	DOB

Parent or Guardian Name (Type or Print) _____ Parent or Guardian Signature _____ Date _____

PART 2 COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD.

- Parent or guardian is responsible for providing the school with any medication, special food or equipment that the student will require during the school day.
- An additional medication permission form is required for any prescription medication given during the regular school day or during school-sponsored activities. Contact school health office for appropriate form.

☐ **ALLERGIES**

☐ Bee Sting Specify Type: _____

☐ Food List food(s): _____

☐ Medication List meds: _____

☐ Environmental/Other: _____

Currently prescribed medications and treatment ☐ Oral antihistamine (Benadryl, etc.) ☐Epinephrine (EpiPen, Auvi-Q)

☐ **ASTHMA (PLEASE ANSWER THE FOLLOWING QUESTIONS)**

1.Has the doctor, nurse or other health professional *EVER* said your child has asthma? ☐ Yes ☐ No ☐ Don't know/not sure

2.If *YES*, does your child STILL have asthma? ☐ Yes ☐ No ☐ Don't know/not sure

3.If *YES*, does your child have a current Inhaler prescription? ☐ Yes ☐ No ☐ Don't know/not sure

☐ **SEIZURE DISORDER**

☐ Absence (staring, unresponsive) ☐ Complex partial ☐ Generalized tonic-clonic

Currently prescribed medications: _____

Medications needed in school: ☐ Yes ☐ No List Med(s): _____

☐ **MENTAL HEALTH**

☐ ADHD ☐ Depression ☐ Anxiety ☐ Other: _____

Currently prescribed medications: _____

Medications needed in school: ☐ Yes ☐ No List Med(s): _____

☐ **DIABETES**

☐ Type 1 ☐ Type 2

Currently prescribed medications: _____

Medications needed in school: ☐ Yes ☐ No List Med(s): _____

☐ **OTHER HEALTH CONCERNS**

Please Specify: _____

_____

_____

CONTINUE ON REVERSE SIDE

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☐ **WELLNESS CHECK (IN THE LAST 12 MONTHS)**

Provider: _____

Date: _____

☐ **DENTAL VISIT (IN THE LAST 12 MONTHS)**

Provider: _____

Date: _____ Sealants Applied ☐ Yes ☐ No

☐ **VISION HISTORY**

☐ Glasses ☐ Contacts ☐ Non Correctable

Provider: _____

Date: _____

☐ **HEARING HISTORY**

☐ Hearing Aid ☐ Non Correctable

Provider: _____

Date: _____

DOES YOUR CHILD HAVE HEALTH INSURANCE? ☐ **YES** ☐ **NO**

If **YES**, which Carrier? _____

*If **NO**, please call 1-800-250-8427 for more information **OR** info.healthconnect.vermont.gov/Medicaid*

OVER THE COUNTER MEDICATION

I give permission for the school nurse or her/his designee to administer the following Over-the-Counter medications to my child (weight appropriate dose) **during the school day when necessary:**

Acetaminophen (generic Tylenol) ☐ Yes ☐ No

Ibuprofen (generic Advil/Motrin) ☐ Yes ☐ No

Diphenhydramine (generic Benadryl) ☐ Yes ☐ No

Antacid (generic Tums) ☐ Yes ☐ No

CONSENT FOR EMERGENCY TRANSPORT/TREATMENT

In case my child has a serious accident or sudden serious illness, I request the school to contact me. If not able to reach me, I authorize school personnel to seek emergency medical care, including transportation (at my expense) to a health care facility. I authorize the medical provider in charge to administer whatever emergency treatment is necessary at my expense.

_____ _____

Printed Name Date

_____

Parent Signature

PARENTAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Physician: _____

Dentist: _____

Other: _____

I give permission for release of information [please check appropriate box(es) below]:

☐ *From the school nurse to my child's physician/medical provider*

☐ *From my child's physician/medical provider to the school nurse*

regarding immunizations, well child exams, and pertinent medical conditions.

_____ _____

Printed Name Date

_____

Parent Signature