Harwood Union Unified School District

2017-18 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/Guardian Printed Name _____ Parent/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.

ASTHMA (PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS) *Please continue to next section: Allergies*

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 ***If YES, Asthma Action Plan Required***

ALLERGIES ☐ N/A *Please continue to next section: Seizure Disorder*

☐ Bee Sting Specify Type: _____

☐ Food List food(s): _____

☐ Medication List meds: _____

☐ Environmental/Other: _____

Currently prescribed medications and treatment ☐ Oral antihistamine (Benadryl, etc.) ☐Epinephrine (e.g., EpiPen)

SEIZURE DISORDER ☐ N/A *Please continue to next section: Mental Health*

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

Currently prescribed medications: _____

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

MENTAL HEALTH ☐ N/A *Please continue to next section: Diabetes*

☐ ADHD ☐ Depression ☐ Anxiety ☐ Other: _____

Currently prescribed medications: _____

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

DIABETES ☐ N/A *Please continue to next section: Other Health Concerns*

☐ Type 1 ☐ Type 2

Currently prescribed medications: _____

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

OTHER HEALTH CONCERNS ☐ N/A ***Please continue to page 2 on the REVERSE SIDE***

Please Specify: _____

_____

_____

Harwood Union Unified School District

2017-18 ANNUAL STUDENT HEALTH QUESTIONNAIRE

STUDENT: Last	First	Middle	DOB

WELLNESS CHECK (IN THE LAST 12 MONTHS) [REQUIRED]

Provider: _____

Date: _____

DENTAL VISIT (IN THE LAST 12 MONTHS) [REQUIRED]

Provider: _____

Date: _____

Sealants Applied ☐ Yes ☐ No

☐ *My child does not have a dentist; **PLEASE** have the Tooth Tutor (Registered Dental Hygienist) help find a dental home and conduct a free dental screening.*

VISION HISTORY [OPTIONAL]

☐ Glasses ☐ Contacts ☐ Non Correctable

Provider: _____

Date: _____

HEARING HISTORY [OPTIONAL]

☐ Hearing Aid ☐ Non Correctable

Provider: _____

Date: _____

DOES YOUR CHILD HAVE HEALTH INSURANCE? ☐ YES ☐ NO *Please continue to next section: OTC Medication*

If **YES,** which Carrier? _____

*If **NO**, please call 1-855-899-9600 for more information **OR** info.healthconnect.vermont.gov/Medicaid*

OVER THE COUNTER MEDICATION *Please continue to next section: Transport/Treatment*

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 *Please continue to next section: Medical Information*

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.

Parent/Guardian Printed Name	Parent/Guardian Signature	Date

PARENTAL/GUARDIANSHIP 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.

Parent/Guardian Printed Name	Parent/Guardian Signature	Date