2020-21 CORNWALL CONSOLIDATED SCHOOL

ANNUAL HEALTH INFORMATION FORM

Parent(s)/ Guardian(s): Please complete in full and return to school as quickly as possible. THANK YOU!

Student Last Name First Name

Grade

Physician: Physician's Phone #

May the school nurse contact the physician regarding information provided on this form Yes

MEDICATIONS

Does your child regularly take medication at home? No

Medication: _____ to treat: _____

Medication: _____ to treat: _____

Medication: _____ to treat: _____

ALLERGIES

Does your child have any allergies? No

__ Food _____ ___ Insect/ Bee Stings _____

__ Medication_____ ___ Animal(s) _____

__ Environmental _____ ___Other _____

Does your child take medication prescribed for allergies? x_No ____Yes; an Allergy Action Plan and a Medication Administration Form will be provided for completion by the parent/ guardian and physician.

ASTHMA

Does your child have Asthma? xNo _____Yes

If yes, please indicate asthmatic episode triggers if known: _____Illnes ____Exercise ____Cold/heat

Environmental: _____Other: _____

Does your child take daily asthma medication to control his/her asthma? _No _____Yes, as noted above ("MEDICATIONS").

Will your child require medication for asthma at school?_No ____Yes; an Asthma Action Plan and a Medication Administration Form will be provided for completion by the parent/ guardian and physician.

STUDENT'S MEDICAL HISTORY

___ Diabetes _____ ADD/ADHD ___ Frequent stomach aches ___ GI/GU Disorders:

___ Seizures _____ Migraine Headaches ___ Frequent Headaches (no migraine

___Emotional/psychological (anxiety, panic attacks, depression, other): _____

____Scoliosis _____ Musculoskeletal: _____

___ Head Injury (concussion/ other, please include dates): _____

___ History of surgery _____

___ Other: _____

CONFIDENTIALITY

I agree that the Cornwall Consolidated School Nurse may share information relevant to my child's health and wellness with faculty and staff. Information will be shared only when appropriate to better address the needs of my child.

Parent Name, printed Date_

Parent Signature_

PLEASE CONTINUE TO THE NEXT PAGE

*** Please note:** Your signature below indicates your permission for any of the listed over-the counter (OTC/ nonprescription) medications/ preparations to be used as needed for your child**.** **<u>If you do not want any of the following to be administered to your child, please cross them off the list and initial</u>. Thank you.**

The following OTC medications/ preparations may be administered to my child as approved by the Region One Medical Advisor, Suzanne Lefebvre, MD:

- **Bacitracin ointment for lacerations, tick bites, abrasions, or local wounds**
- **Benadryl for allergic reactions**
- **Burn-Jel for first degree burn only**
- **Calamine lotion for itchy rash or insect bites**
- **Hydrocortisone 0.5-1% cream for minor skin rashes and itch**
- **Ibuprofen (Motrin/ Advil) for headaches, cramps and mild to moderate discomfort**
- **Sterile isotonic saline eye drops for allergy/dry eye relief**
- **Sunscreen for prolonged sun exposure**
- **Sting Relief wipe for bee sting and insect bites**
- **Acetaminophen (Tylenol) for headache, cramps and mild to moderate discomfort**
- **Vaseline/ Blistex for chapped lips/skin**
- **Epipen auto-injector, appropriate dose, to be given by appropriately trained unlicensed personnel for treatment of anaphylaxis**

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* Please note: Generic medications (for example, acetaminophen, not Tylenol) may be used. Manufacturer's recommended dosage guidelines will be followed.

My signature below gives permission to the school nurse and other appropriate personnel to administer the above medications/ preparations during the 2020-2021 school year. I will notify the school nurse of any changes to the information provided on this form. If my child is prescribed medication to be administered during the school day I will supply the medication and required documentation from the prescribing physician.

Parent/ Guardian Signature

Region One Medical Advisor _____ Date _____

Suzanne Lefebvre, MD