# CORNWALL CONSOLIDATED SCHOOL
# ANNUAL HEALTH INFORMATION FORM

***Parent(s)/Guardian(s): To update your child's health information, please complete <u>both sides</u> of this form and return it to the school health office by the end of the first week of school.***

Student Last Name _____ First _____ MI _____Grade _____

Physician: _____ Phone _____

May the school nurse contact the physician about health conditions listed on this form? ___ Yes ___ No

May the school nurse share appropriate medical concerns with your child's bus driver? ___ Yes ___ No

Section 1: **MEDICATIONS:**

1. Does your child take any medication at home? ___ No, proceed to next section. ___ Yes, please list and use comment area on back of form for additional listings.

   Name: _____ Reason _____

   Name: _____ Reason _____

   Name: _____ Reason _____

   Name: _____ Reason _____

Section 2: **ALLERGIES:**

1. Does your child have any allergies? ___ No, proceed to next section ___ Yes, complete this section and check all that apply.

   __ Food (list food(s)) _____ ___ Insect Sting (list insect) _____

   __ Medication (list medication(s)) _____ ___ Animal(s) _____

   __ Environmental (list) _____ ___ Other _____

2. Does your child have medication prescribed for allergies: __ No __ Yes, I will provide a completed Allergy Action Plan **

Section 3: **ASTHMA:**

1. Does your child have Asthma? ___ No, proceed to next section. ___ Yes, please complete below.
2. What are your child's usual triggers for their asthma? Check all that apply: ___ Illness ___Exercise ___ Cold/heat
   Environmental (list): _____ Other: _____
3. Does your child take daily asthma medication to control his/her asthma? ___ No ___ Yes, as listed in medication section above.
4. Will your child require asthma medication while at school? ___ No ___ Yes, I will provide a completed Asthma Action Plan ** and a completed Medication Administration Form **

Section 4: **OTHER CONDITIONS:** (check all that apply)

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

___ Seizures, If yes, type: _____ ___ Migraine Headaches ___ Frequent Headaches (not migraines)

___ Emotional/psychological :( i.e. panic attacks, stress, depression):_____

___ Scoliosis ___ Muscular Skeletal Disorders: _____

___ Head Injury (i.e. concussion) within the last year (include dates): _____

___ Surgeries within the last year (include dates): _____

___ Other: _____ **OVER →**

Section 5: **CONFIDENTIALITY:**

To provide the best learning environment and support for your child, and/or for the safety of your child while in school, it is sometimes necessary and helpful for the school nurse to inform your child's teachers, administrator and/or other professional school staff about your child's health issues. Please use the space below to indicate any information you would like to remain confidential with the school nurse and would like **not to be shared**.

Section 6: **ADMINISTRATION OF MEDICATIONS BY SCHOOL NURSE AND SCHOOL PERSONNEL:**

The school nurse has authorization by the school medical advisor to administer Acetaminophen and Ibuprofen to your child while in school. The administration of these medications is prescribed according to a written protocol for the nurse to follow. The purpose of these protocols is to allow the nurse to provide occasional relief of minor symptoms while your child is in school (fever, orthodontic pain, headache, menstrual cramps, minor aches and pains, earache). The dosage will be determined by the age and/or the weight of the child according to the protocol and/or manufacturer's recommendation. Should a child require more frequent use of any of these medications, I understand that I will be contacted by the school nurse to obtain a medication order specific to my child.

- Acetaminophen (Tylenol) ___ Yes ___ No
- Ibuprofen (Advil, Motrin) ___ Yes ___ No

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Section 7: **COMMENTS AND AUTHORIZATION:**

Use this space to add additional comments, list additional medications or conditions:

I understand that it is my obligation to notify the school nurse of any changes to the information provided on this form; that it is my responsibility to provide to the school nurse any medication and appropriate written documentation by a physician for my child to carry and/or to have the school nurse administer any medication for which my child has been prescribed during the school day.

| _____ | _____ | _____ |
|---|---|---|
| **Printed Name of Parent/Guardian** | **Signature of Parent/Guardian** | **Date** |

** All forms mentioned above are available from the school nurse or downloadable from the school's website under Health Office.