SOUTH BURLINGTON SCHOOL DISTRICT - FHTMS
2018-2019 ANNUAL HEALTH UPDATE & EMERGENCY AUTHORIZATION FORM

In an effort to provide a safe and healthy school experience for your child, we ask you to take a few minutes to complete this Health Update for the upcoming school year. This is one way we can assure that your child's needs will best be served in an emergency situation. If your child will be taking prescription medication or using an inhaler at school, we will need a physician's order.

Name____ **Birth date** ______________ **Grade**________

My child has had a comprehensive annual well-care visit* in the past year. Yes (date) _______________ NO______
**A comprehensive well-care (physical) visit is not an appointment for sickness, injury, or chronic health need.*

Doctor's Name _________________________ Phone _______________________________________

My child has had a dental exam in the past year. Yes (date) _______________________________ NO ______

Dentist's Name _________________________ Phone _______________________________________

Has your child been to any other health care provider in the past 12 months? YES_____ NO______

(i.e. optometrist, ENT, allergist, psychiatrist, other)

- If yes, name of provider: ____
- Reason/outcome/treatment: ____
- Date of visit (most recent): ____

INSURANCE

Yes No Does your child have health insurance? Company Name ________________________________

If No, dial 1-855-899-9600 for Vermont Health Connect or

https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action

The following over-the-counter medications are used in the health room. Please cross out those which you **DO NOT** want your child to have during the course of routine visits to the health room and sign below.

BACITRACIN OINTMENT	HYDROCORTISONE CREAM 1% (anti-itch)	IBUPROFEN (ADVIL)
ACETAMINOPHEN (TYLENOL)	COUGH DROPS	FIRST AID CREAM
CALAMINE LOTION	ANTACID TABLETS	ALOE VERA GEL
INSECT STING RELIEF	MOUTH WASH	ORAL PAIN RELIEF
BENADRYL (FOR EMERGENCY IF PARENT CANNOT BE CONTACTED)		

I give my permission for school staff to administer the medications and products listed above. If my child is injured at school and emergency care is necessary, I give school staff permission to seek medical care while trying to reach a parent/guardian.

I acknowledge that I am responsible for making after-school personnel aware of my child's health care needs and providing the personnel with necessary medication and treatment procedures/instructions. I am also aware that the school nurse is not available for my child's medical needs after school hours (3:20 p.m.).

Parent/Guardian Signature____Date_______________________

Erin Phelan, RN **652-7106** **Fax 652-7140**

--PLEASE COMPLETE THE OTHER SIDE—

STUDENT'S MEDICAL HISTORY (CONTINUED):

Please check if your child has any of the following conditions and describe current treatment:

❑ **ASTHMA**

Has a doctor, nurse or health professional EVER said that your child has asthma?

Yes______ **No**______ **Don't know/not sure**______

If yes, does your child STILL have Asthma?

Yes______ **No**______ **Don't know/not sure**______

If yes, please provide school with an updated Asthma Action Plan.

Treatment: ____

❑ **ALLERGIES** *Requiring Epinephrine*

Allergic to: ____

Treatment/Medication: ____

❑ **OTHER ALLERGIES** *Not requiring epinephrine*

Allergic: ____

Treatment/Medication: ____

❑ **DIABETES**

Type: ____

Treatment: ____

❑ **SEIZURES/EPILEPSY**

Type: ____

Treatment: ____

❑ **BLEEDING DISORDER** ____

❑ **EAR/HEARING PROBLEMS**

Condition: ________________________Treatment: ____

❑ **CORRECTIVE LENSES** *(GLASSES/CONTACTS)*

Condition: _____________________________ Date of last vision exam: __________ Eye Specialist:_______________

❑ **HEART PROBLEMS**____

❑ **HIGH BLOOD PRESSURE**____

❑ **MENTAL HEALTH CONDITION**____

Treatment: ____

❑ **MUSCULAR WEAKNESS OR PARALYSIS**____

❑ **MIGRAINE HEADACHES**____

Treatment: ____

❑ **HOSPITALIZED/RECENT SERIOUS ILLNESS, INJURY, ACCIDENT OR SURGERY**____

____ Date:_________________

❑ **ANY PROBLEMS** *(not listed above)* ____

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PLEASE CONTACT THE SCHOOL NURSE TO PROVIDE MORE INFORMATION FOR ANY OF THE ABOVE CONDITIONS.

❑ **MEDICATIONS* TAKEN ON A REGULAR BASIS:**

Name of Medication(s):____

____

Dosage(s):____

Time(s) of day taken:____

Reason(s):____

***Prescription* medication** needs a written health care provider's order and written parental permission**.**

***Non-prescription* medication** needs only written parental permission**.**

***All medication** needs to be brought to the health office, in the original container, by an adult**.**

____ ________________

Parent/Guardian Signature **Date**