

WINNISQUAM REGIONAL SCHOOL DISTRICT
ANNUAL HEALTH INFORMATION UPDATE

BOTH SIDES TO BE COMPLETED BY PARENT/GUARDIAN AND RETURNED TO THE SCHOOL NURSE.

Student's Name _____ **Date of Birth** _____ **Grade** _____

Does the student currently have or has had in the past year any of the following conditions?

Condition	YES	NO	Condition	YES	NO
Allergy			Hearing Loss/Hearing Aide		
ADHD/ADD			Heart Condition/irregular heartbeat		
Anemia			Hepatitis		
Asthma			High blood pressure		
Back/Neck Injury			Mononucleosis		
Bladder/Kidney Disease			Orthopedic/Bone injury		
Convulsions/Seizures			Psychological/Psychiatric		
Diabetes			Respiratory condition other than asthma		
Head Injury/Concussion			Surgery		
Headaches (frequent)			Other (explain below)		

Please give details and dates on all of the above marked YES _____

Is your child taking any **medication** on a regular basis (prescription or non-prescription)? ___ NO ___ YES.
List the medication, dose, time, and reasons for taking. _____

*** If your child needs to take prescribed medication during the school day, please see the school nurse for additional paperwork. Please review our medication Policy in the Student Handbook.**

If your child has received immunizations since last reporting to school **please provide a copy of the current immunization record from your primary care provider.**

Primary Care Provider _____ Phone _____

Dentist _____ Phone _____

Does your child have health insurance? ___ NO ___ YES. Health Insurance Company _____

Policy/Group # _____ Subscriber _____

I request that the school call me if my child is injured or becomes ill. If they are unable to reach me, I authorize the school to call emergency contacts on file with the school. I understand that the school will call 911, as deemed necessary by school officials. I authorize the school to contact the physician/PCP listed above for the purposes of consultation and direction when my child is sick or injured as well as obtain medical information regarding immunizations, medication/treatment orders and physical exams. I also allow the school nurse to share health information with other school personnel working with my child if relevant. The school may make whatever arrangements seem necessary, including epinephrine for life threatening anaphylaxis (severe allergic reaction). I authorize the hospital staff to provide medical care to my child. I understand that any and all expenses incurred for emergency transportation and medical care of my child are my responsibility and not that of the Winnisquam Regional School District.

Signature of Parent/Guardian _____ Date _____

PLEASE COMPLETE BACK SIDE OF FORM

WINNISQUAM REGIONAL HIGH SCHOOL
OVER THE COUNTER MEDICATIONS
PARENT AUTHORIZATION

By checking the medications below, I give permission for my child to receive the following during the school year. I will hold harmless any member of the school staff designated to give this non-prescribed medication.

- _____ Diphenhydramine, (Benadryl) for allergic reaction
- _____ Acetaminophen (Tylenol) for headache, fever, minor pain
- _____ Ibuprofen (Advil) for headache, fever, minor pain
- _____ Antacid tabs (Tums) for acid reflux and upset stomach
- _____ Bismuth subsalicylate (Pepto Bismo) for upset stomach, diarrhea
- _____ Phenylephrine hydrochloride (non- drowsy pseudoefed) for congestion
- _____ Loperamide HCL/Simethicone (Immodium) for diarrhea
- _____ Refresh eye drops
- _____ Caladryl lotion for skin rashes such as poison ivy
- _____ ambusol- for mouth or dental pain

_____ **Please do not give any medications without a phone call to me first.**

_____ **Please notify me if my child comes frequently to the nurse's office**

I understand it will be my responsibility to notify the School Nurse should there be a change in the medical status or developed allergies for my child.

Signed _____ Date _____
Parent or Legal Guardian