Lincoln Community School

HEALTH FORM – CONFIDENTIAL 2023-2024

Student's Name: _____________________________ D.O.B. __________Grade__________

Contact Information: *(please provide name, relationship to student, phone number)*

Primary contact: ____

Secondary: ____

Third: ____

Is your child covered by health insurance? No___Yes (list name of insurer)_______________

Doctor's Name: ___________________Phone # _________Date of Last Physical Exam_____

Dentist's Name: ___________________Phone # ________Date of Last Dental Exam________

List of allergies/typical reactions:____

____

Does your child have an ***epi-pen****?* ____No____Yes____Unsure

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

If yes, does your child ***STILL*** *have asthma?* ____No ____ Yes _____Unsure
Does your child require any use of an ***inhaler****?* ____No ____ Yes _____Unsure

Current Medications

(including those given at home) ____
name of Medication dose time given

____
name of Medication dose time given

Will your child need to take medication at school regularly? Yes ______ No _______

Emergent Needs

In case of an accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician above and follow his/her instructions. I agree that relevant medical information may be released to the staff as necessary.

If your child needs to be transported to a hospital, what is your preference?

Porter Hospital ________ UVM Medical Center ________ No Preference ________

Permission to Exchange Medical Information and Receive Emergency Care

I give the Lincoln Community School Nurse and my child's doctor permission to exchange information concerning my child's health, safety, and immunization status at school.

______________________________ ______________
(parent or guardian signature) (date)

In the event of a serious accident or illness, I hereby authorize the school to contact my child's physician and/or to seek emergency medical care including transportation to a medical facility. I hereby authorize the physician and emergency room staff to administer care that is deemed necessary. I understand every effort will be made to contact family first.

______________________________ ______________
(parent or guardian signature) (date)

(turn over)

Student Medical Information:

Is the student currently being treated for any illness, physical or mental health problem the school should know about? _____No _____ Yes
Doctor's name if different from above _________________
Describe current health problem(s): ____

Medical History:
1. Please describe anything unusual that occurred during pregnancy or at birth of this child.
____

2. Serious past illnesses/injuries: ____

3. Hospitalizations, operations (give age): ____

4. History of serious trauma to the head, and/or concussion
_____No _____ Yes (if yes, please describe): ___________________________________

5. Childhood illness history (select all that apply)
__ chicken pox
__ fever induced seizures
__ measles
__ scarlet fever
__ recurrent strep throat
__ pneumonia
__ frequent headaches/migraines
__ frequent bloody noses

6. Ear infections? __ No __ Yes infrequent (2-3/yr) ___ frequent (more than 3/yr) ___
Has hearing ever been tested? ____ Yes ____No
Any hearing difficulties? ____ No ____ Yes, describe
____

7. Eyes – Has vision been tested? ____No ____ Yes
Any problems? ___ No ___ If Yes, describe eye correction (Glasses) needed
____

8. Long-term or chronic illnesses or problems and current treatment (i.e. asthma triggers, diabetes, bed wetting, cystic fibrosis, head banging, motor difficulties)
____
____

Permission for Treatment:

Permission to give *Tylenol* (its generic counterpart)
Yes ______ No _______

Permission to give *Ibuprofen* (its generic counterpart)
Yes ______ No _______

Permission to give *Benadryl* (its generic counterpart)
Yes______ No _______

Permission to give *Lactaid* (its generic counterpart)
Yes______ No _______

Permission to apply *sunscreen*
Yes ______ No _______

Permission to give *Tums*
Yes _______ No __

Permission to give *cough drops*
Yes ______ No _______

Above medications will be given according to the directions on the bottle unless you indicate your preference here:

____

Signature:____ Date:__________