Student Name _____
(Please print in ink) Last First M/F Date of Birth Grade

The Newton School - Health Information

Legal Guardian: _____ Relationship _____
Physical address:

_____
Street City State Zip code

Parent 1/ Guardian Information	**Parent 2/ Guardian Information**
Name _____	Name _____
Custodial Parent ____Yes _____ No	Custodial Parent ____Yes _____ No
_____	_____
Mailing Address Town	Mailing Address Town
Home #: _____Cell #_____	Home #: _____Cell #_____
Employer :_____ Work #_____	Employer :_____ Work #_____
Email: _____	Email:_____
Occupation:_____	Occupation:_____

Please list any adults below who may be contacted and assume temporary care of your child if the school cannot reach you by phone. This adult must be willing and able to take care of your child during school hours.

Emergency contact 1:	**Emergency contact 2:**
Name: _____	Name: _____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
Home #:_____ Cell #: _____	Home #:_____ Cell #: _____

Insurance information

Dr. Dinosaur/Medicaid MVP VHAP PCP VT BC/BS CIGNA None Other: _____
Policy number: _____ Group number _____

If No insurance, **dial 1-855-899-9600** for VT Health Connect :https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action]

Doctor's Name:	Phone
What was the date of your child's last well child visit* received by their primary care provider? **Date:**_____	
Dentist's Name:	Phone
What was the date of your child's last dental exam received by their dentist? **Date:**_____	

*** A comprehensive well-care (physical) visit is not a sick appointment.**

HealthHub: Students at our school have access to medical care through HealthHub School Based Clinic. This provides them the opportunity to see a Pediatrician. This doctor can help with health maintenance for certain problems (asthma, depression, ADHD), sick visits, sports physicals/well child check-ups, immunizations etc. This doctor would not replace your primary care doctor but provides a service to help parents and students miss less work/class time. All visit notes are shared with your child's primary doctor. In addition, dental hygiene and mental health services are available. I am interested in my child receiving HealthHub Services and would like more information.

Signature of Guardian_____

OVER →→→→

Student Name _____

STUDENT MEDICAL HISTORY:

1. Does your child have any **allergic reactions** from any of the following? (Check all that apply.)

☐ Outside or Indoor allergies, (*for example: hay fever, grass, pollen, cats …*) **Please list below ↓**

☐ Food Allergies (*for example: peanuts, milk, wheat ...)* **Please list below ↓**

☐ Insect or Animal Allergies (*for example: bees, wasps, cats…)* **Please list below ↓**

☐ Medicine or shots (*immunization*). **Please list below ↓**

☐ **No**, my child has **no allergies** that I know of.

2. Does your child have an **Epi-Pen** or **Auvi-Q?** ☐ Yes ☐ No If **YES**, please bring one to school w/an **Emergency Plan**

My child is allergic to: *Example (amoxicillin)*	**What happens when your child has a reaction?** *Diarrhea, rash, difficulty breathing, etc.*

3. ASTHMA: Has a doctor, nurse, or other 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, TNS needs the **Asthma Action Plan yearly**

If yes, what **triggers** an asthma attack (eg. exercise, cold/flu, etc.)?_____

4. Is your child taking any **prescription medicines**? **(Please include medications administered at home and during the school day)**

☐ Yes - Please list the child's medicines including inhalers or breathing treatments (below). How often is inhaler typically used? (e.g with exercise, weekly, monthly, seasonally, seldom)_____

☐ No. My child does not take any prescription medicines. (If no, go to question #5)

Name of medicine: ***Example:*** *dexadrine*	**Amount /dose** *10mg*	**How many pills or doses does your child take at** *1 morning*	*½ noon*	*dinner*	*bed*
		___morning	____noon	____dinner	___bed
		___morning	____noon	____dinner	____bed
		___morning	____noon	____dinner	____bed

****If daily medication is to be administered at school, it must accompany a signed doctor's order and be in a current pharmacy bottle.**

5. My child wears **corrective lenses/glasses? YES_____ NO _____ Hearing aids? YES _____ NO _____**

6. Other **health concerns?** (eg.diabetes, seizures, ADHD, depression, anxiety, constipation, etc.)_____

7. The following **non-prescription medications** are available from the school nurse and can be given according to age, weight and manufacturer's instructions at nurse/designee discretion. Parents will be notified of any student under grade 6 receiving Ibuprofen, Acetaminophen, Benadryl. ***Please cross out*** if you do not wish your child to receive this medication.

Ibuprofen Acetaminophen Antihistamine Antibiotic ointment Antacid tabs Calamine lotion

Hydrocortisone ointmt. Sunscreen Vaseline Eye Wash Eye drops (saline) Cough drops Orajel

I give permission to exchange health information between my child's primary care provider or dental provider and the school nurse, including vision and hearing screening information:

Parent/Guardian Signature _____

In the event that your child has serious illness or injury, and if we are unable to reach a parent/guardian, please understand that The Newton School personnel will seek emergency medical care, including transportation to a medical facility. Emergency Personnel will make further decisions based on need. I understand the plan.

Parent/Guardian Signature_____