Washington Central Unified Union School District
Annual Student Health Update - 2020-2021

Please circle your child's school: *Berlin Calais Doty East Montpelier Rumney U32*

Student's Name:_____ Gender: _____ Grade:_____
Age:_____ Date of Birth:_____ Teacher/TA:_____

Please list a phone number where you can be reached during the school day:

Parent/Guardian 1._____ Phone: _____

Parent/Guardian 2._____ Phone: _____

Child lives with: please list all that apply, such as parent(s), step-parent(s), guardian, siblings_____
_____

Please give the name of nearby relatives/friends who will be able to pick up and assume temporary care of your child if you cannot be reached.

Name _____ Phone _____
Name_____Phone_____

****

PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION FOR YOUR CHILD

(even if the information is on last year's form)

Yes No **Allergies**: If yes, please check and describe below:
_____ **LIFE-THREATENING ALLERGIES**_____
_____ food allergies _____
_____ medication allergies _____
_____ environmental or other _____

Yes No Seizures: If yes, please describe_____
Yes No ADHD: _____
Yes No Has a **doctor**, nurse, or other health professional EVER said that your child has asthma?
Yes No If yes, does your child STILL have asthma?
Yes No If yes, does your child have a current VT Asthma Action Plan?
If yes, please give a copy of the VT Asthma Action Plan to the school nurse.
Yes No Diabetes: _____
Yes No Eyeglasses/Contacts: for what activity? _____
Yes No Hearing or ear problems: hearing aids; frequent infections; tubes; etc:_____
_____
Yes No Medication(s) taken at home : _____
Yes No Medication(s) needed at school: _____
*New permission forms must be completed **yearly** for medications at school. Get forms from the school nurse or website.*
Yes No Are there other health conditions the school nurse should know about?_____
_____

PLEASE COMPLETE SIDE 2 ➔ ➔ ➔ ➔ ➔ ➔

-SIDE 2-

Student's Name _____ DOB_____

Parents/Guardians: Do you give permission for the school nurse or designee to give the following to my child (*in an age & weight appropriate dose*) during the school day when necessary?

Yes No Acetaminophen (generic Tylenol)
Yes No Ibuprofen (generic Advil, Motrin)

***Signature of Parent/Guardian:* _____ *Date* _____

Yes No Has your child had any recent life events that might impact him/her socially and /or emotionally? (i.e. loss of a relative, military deployment of a family member, family separation, etc.)
If yes, please explain: _____
_____

Yes No Is your child receiving counseling or psychological services? If yes, please explain:_____
_____

Yes No Does your child have health insurance? *(If no, call 1–800-250-8427 for lower cost insurance.)*

_____

RELEASE OF MEDICAL INFORMATION

Please list your child's:

Doctor: _____Tel: _____ Date of last physical:_____
Dentist: _____Tel: _____ Date of last visit:_____
Eye Doctor _____ Tel: _____ Date of last visit:_____
Other provider(s): _____ ____Tel: _____ Date of last visit:_____

I give my permission for Bonne Dunham, the school nurse at Rumney Elementary School, to contact the health care providers listed above to release and receive information concerning _____'s health conditions, medications, and immunizations. **I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires.**

***Signature of Parent/Guardian:* _____*Date*_____

****

IN CASE OF AN EMERGENCY school personnel will seek emergency medical care, including transportation to the hospital, if needed. I authorize the hospital to administer emergency treatment to my child as necessary.
Parent(s)/Guardian(s) will be notified as soon as possible in an emergency.

***Signature of Parent/Guardian:* _____*Date*_____