Washington Central Unified Union School District
Annual Student Health Update & Emergency Authorization Form - 2022-2023

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

Student's Name:_____Gender: M F GN Pronouns: he/him she/her they/them
Grade:_____ Age:_____ Date of Birth:_____ Teacher::_____

Please list a phone number where you can be reached during the school day:
Parent/Guardian 1._____ Phone: _____
Parent/Guardian 2._____ Phone: _____

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 _____

PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION FOR YOUR CHILD
(even if the information is on last year's form)

❒Yes ❒No **LIFE-THREATENING ALLERGIES (requiring EpiPen/ Epinephrine)**
--If **YES**, list allergens: _____
--If **YES**, please bring an EpiPen/Epinephrine to keep at school.

❒Yes ❒No **Allergies/Sensitivities (non-life threatening):** If yes, please check and ***describe*** below:
___ Food(s): _____ Reaction:_____
___ Environmental or other: _____Reaction:_____
___ Medication: _____Reaction:_____

❒Yes ❒ No Dietary Restrictions: If yes, please describe_____
❒Yes ❒ No Seizures: If yes, please describe_____
❒Yes ❒No ADHD/ADD: _____
❒Yes ❒No Diabetes: _____
❒Yes ❒No Eyeglasses/Contacts: if Yes, indicate for what activity? _____
❒Yes ❒No Hearing or ear problems: hearing aids; frequent infections; tubes; etc:_____
_____
❒Yes ❒No Are there other health conditions the school nurse should know about?_____
_____
❒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. Contact the school nurse for forms if needed.*

School stocked OTC Medications: (please cross out any medications NOT ALLOWED for your child)

Acetaminophen (tylenol) Diphenhydramine (benadryl) Antacid (tums) Hydrocortisone cream Lip Balm

Ibuprofen (advil) Antibiotic ointment Aloe Vera gel Cough drops Oral benzocaine (ora-jel) Insect Repellant

Calamine lotion

❒Yes ❒ No Sunscreen (***school provided***) ❒Yes Sunscreen (only as ***provided by parent/guardian)***

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

-PLEASE TURN OVER AND COMPLETE SIDE 2 OF FORM-

Student's Name _____ **DOB**_____

❒**Yes** ❒**No** **Permission to test student for Covid-19 in Health Office (if symptomatic)**

❒Yes ❒ No Does your child have health insurance?

- **If No, call 1- 855-899-9600 for Vermont Health Connect info or check out the website: [https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action]**

❒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 (has an active inhaler prescription)?

❒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 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:**_____

_____

_____

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RELEASE OF MEDICAL INFORMATION

Please list your child's:

Doctor, PCP: _____ Tel: _____ Date of last annual well child visit:_____

Dentist: _____ Tel: _____ Date of last dental exam:_____

Eye Doctor _____Tel _____ Date of last visit:_____

Other provider(s): _____ Tel: _____ Date of last visit:_____

I give my permission for the school nurse to contact the health care providers listed above to release and receive information concerning my child's health conditions, medications, and immunizations.

I understand that I may revoke this consent at any time by providing written notice, and it automatically expires at the end of this current school year.

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

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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*_____