Your School Letter Head Here

**FORM FOR NEWLY ENROLLED STUDENTS**

Your Town, Vermont **Health Information Form**

**Student’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (He/her/they) Birthdate**\_\_\_\_\_\_\_\_\_**Age\_\_\_\_Grade \_\_\_**

**MEDICAL HISTORY**

1. Has your child ever been a **patient** **in a hospital** (other than a few days after birth)?

No (If no, go to question #2.)

Yes (If yes, explain why and when below.)

2. Birth History: Was your child born before or after their due date? If so, how many weeks? \_\_\_\_\_\_\_\_\_\_. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| **My child was in the hospital because:** | **When** |
| **Example:**  Bike accident-concussion | 5 years old |
|  |  |
|  |  |

3. Is your child taking any **prescription medicines**?

Yes - Please list the child’s medicines below OR  No. My child does not take any prescription medicines. (If no, go to question #4 ) Does your child use an inhaler or breathing treatments?  Yes  No. If YES, please list medicine below.

|  |  |  |
| --- | --- | --- |
| **Name of medicine** | **Amount /**  **size of pill** | **How many pills or doses does your child take at** |
| **Example:**  Dexadrine | 10 mg | 1 morning 1 noon dinner \_\_bed |
|  |  | morning noon dinner bed |
|  |  | morning noon dinner bed |
|  |  | morning noon dinner bed |

4. What **over-the-counter medicines/herbal or homeopathic remedies** does your child take **regularly**?

Vitamins  Herbal medicine (please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other medicines like Tylenol, Advil or something else? (Please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **None**, my child does not take any of these regularly.

5. Does your child receive other therapies? (like PT, OT, Speech, cupping, sensory or percussion vests, art therapy, coining, hearing aids, braces, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\* Please note: Confidential information about your child’s health may be shared only with other school staff that need to know to protect your child’s safety. They are told to keep this health information private and not to share with anyone else. If there is health information you would like not to be shared, please contact the school nurse.*

**Turn page over please!**5. Does your child have any **allergic reaction** (bad effect) 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.

Does your child have an **Epi-Pen** or **Auvi-Q**, or emergency medicines for **seizures or diabetes**?  Yes  No If YES, please bring one to school.

|  |  |
| --- | --- |
| **My child is allergic to:** | **What happens when your child has a reaction?** |
| **Example:**  amoxicillin | Diarrhea (runny poop) |
|  |  |
|  |  |
|  |  |

6. Has your child had any of the following **medical problems or injuries**? (Examples in parenthesis)

Describe **your child’s** problem for each **Yes** on the lines at the bottom of the page **🡫** .

|  |  |
| --- | --- |
| **Chicken Pox--**Date if had chickenpox: | Yes  No |
| **Surgery --**Date of any surgeries: | Yes  No |
| **Head Injury** or **Concussion** | Yes  No |
| **Ear** infections *(often has them, ear tubes, etc.)* | Yes  No |
| **Nose** problems *(sinus infections, nose bleeds)* | Yes  No |
| **Eye** problems *(blurry vision, wears glasses, lazy eye)* | Yes  No |
| **Hearing** problems *(has trouble sometimes, wears hearing aid)* | Yes  No |
| **Mouth or throat** problems *(Strep throat, swallowing problems)* | Yes  No |
| **Constipation** *(problems having a bowel movement (BM))* | Yes  No |
| Problems **peeing** *(bed wetting, pain when peeing)* | Yes  No |
| **Back** problems *(crooked back, back pain)* | Yes  No |
| **Muscle and bone** problems *(weak muscles, pain in joints)* | Yes  No |
| **Skin** problems *(acne, flaking skin, rashes, hives)* | Yes  No |
| **Seizures** *(shaking fits or convulsions)* | Yes  No |
| **ADD/ADHD** *(problems paying attention, sitting still)* | Yes  No |
| **Breathing** problems *(cough, asthma)* | Yes  No |
| **Heart** problems *(fast or irregular heartbeat, murmur, birth defect)* | Yes  No |
| **Feelings or emotions** (*depression, anxiety, fears)* | Yes  No |
| **Does your child see other specialist? If yes, then who:** | Yes  No |
| **Other:** |  |

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**Signature and /Relationship to Student**  **Date**