Grade_____

2022-23 CCS ANNUAL HEALTH INFORMATION FORM

Parent(s)/ Guardian(s): ***Please complete in full*** *and* ***return to school as quickly as possible.***
THANK YOU!

Student's First Name_________________________ **Last Name**_______________________

MEDICATIONS

Does your child regularly take medication at home? No__________ Yes*_____________

*If yes, note medication(s):____

ALLERGIES

Does your child have any allergies? No_____ Yes_____ (please specify below)

____ Food _________________________ ____Bee Stings

____ Medication________________________ ____ Animals ______________________

____ Environmental ______________________ ____Other _______________________

Does your child take medication prescribed for allergies? ______No _____Yes - An Allergy Action Plan and a Medication Administration Form will be provided for completion by the parent/ guardian and physician.

ASTHMA

Does your child have asthma? No______ Yes______

If yes, asthmatic episode triggers (if known): Illness______ Exercise______ Cold/ Heat______

Environmental: _______________________ Other: ____________________________

Will your child require an inhaler or other medication for asthma at school? No______

Yes_____ An Asthma Action Plan and a Medication Administration Form will be provided for completion.

STUDENT'S MEDICAL HISTORY

___ Diabetes _____ ADD/ADHD ___ Frequent stomach aches ___ GI/GU Disorders

___ Seizures _____ Migraine headaches ___ Frequent headaches (other than migraines)

___Emotional/psychological (anxiety, panic attacks, depression, other): ____________________

_____Scoliosis _____Musculoskeletal: ____

___ Head Injury/ Concussion (please note dates):_____________________________________

___ History of surgery:____

___ Other? ____

PLEASE complete p. 2...............

Your signature below indicates your permission for the following medications/ preparations to be used if needed for your child. Manufacturer's recommended dosage guidelines will be followed. **IF YOU ARE WITHHOLDING PERMISSION for any of the following to be administered to your child, please cross off the list and initial.** **Thank you.**

The following medications/ preparations may be administered to my child as approved by the Region One Medical Advisor, Suzanne Lefebvre, MD:

- **Acetaminophen (Tylenol)**
- **Ibuprofen (Motrin/ Advil)**
- **Tums (calcium carbonate)**
- **Benadryl (for severe allergic reactions only)**
- **Sterile eye drops for dry eye relief or to flush eyes**
- **Bacitracin ointment**
- **Hydrocortisone 0.5-1% lotion**
- **Moisturizing lotion/ Vaseline/ Blistex for dry skin/ lips**
- **Calamine lotion**
- **Sting Relief for bee stings/ insect bites**
- **Burn-Jel for first degree/ superficial burns**
- **Insect Repellant**
- **Sunscreen**
- **Epipen auto-injector to be given by appropriately trained unlicensed personnel for treatment of anaphylaxis/ in the event of an emergency**

My signature below gives permission to the school nurse and other appropriate personnel to administer the above medications/ preparations during the 2021-22 school year. I will notify the school nurse of any changes to the information provided on this form. If my child is prescribed medication to be administered during the school day I will supply the medication and required documentation signed by the prescribing physician.

CONFIDENTIALITY: I agree that the Cornwall Consolidated School Nurse may share information relevant to my child's health and wellness with faculty and staff. Information will be shared only when relevant and necessary to address the needs of my child.

Parent/ Guardian Signature____

Parent/ Guardian Name (please print)__________________________________

Date________________________________