

Grade_____

2021-22 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 _____

Region One Medical Advisor: Suzanne Lefebvre, MD