2017 Arlington Memorial 2018
Middle School & High School

Annual Health Update & Emergency Authorization Form

Student's name_____DOB_____Grade_____

Mailing address_____Physical address_____

Student lives with_____

Mother's name_____ Home #_____
Cell #_____Work #_____E-mail_____

Father's name_____Home #_____
Cell #_____Work #_____E-mail_____

Step Parent's / Guardian's name_____Home #_____
Cell #_____Work #_____E-mail_____

Emergency contact	Relationship to Student	Home #	Cell #	Work #

Sibling_____age_____ Sibling_____age_____Sibling_____age_____
Sibling_____age_____ Sibling_____age_____Sibling_____age_____

Doctor's Name:
Date of your student's last comprehensive annual well care visit received in their medical home? A comprehensive well-care (physical) visit is not a sick appointment **Date**:_____(month/year is fine)
Dentist's Name:
What was the date of your student's last dental exam? **Date**:_____(month/year is fine)

ALLERGIES: Serious Requires epinephrine:

No Yes (please describe) _____

(Please have your student's doctor fax an allergy action plan and bring Epi-pen to the school nurse, fax # 375-1547)

ASTHMA: Has a doctor, nurse, or other health professional EVER said that your student has asthma?

No Yes Don't know/not sure

○ If **yes**, does your child STILL have asthma? **No Yes Don't know/not sure**

(Please have your student's doctor fax an asthma action plan and bring inhaler to the school nurse, fax # 375-1547)

USE CORRECTIVE LENSES? No Yes HEARING AIDS? No Yes

Student's name_____DOB_____

- **MEDICATIONS taken on a regular basis:**

Medication Dose When taken What is this taken for?

***If your student needs to take a prescribed medication while at school or during any school sponsored events, have the doctor fax an order and bring the medication to the school nurse. Medication must be in the original prescription bottle, fax # 375-1547**

Please indicate if student has had or is currently under treatment for any of the following conditions:

_____Any medical diagnosis? _____
_____Bleeding disorders _____
_____Diabetes_____
_
_____Ear / hearing problems _____
_____Heart problems _____
_____High blood pressure_____
_____Hospitalized for serious illness, surgery or accidents? _____
_____Mental health conditions and treatment (Please explain):_____
_____Muscular weakness or paralysis _____
_____Migraine headaches _____
_____OTHER allergies: (Please list) _____
_____Seizures_____
_____Please add any problems not listed _____
Notes:

(Please provide an up to date immunization record for your student, fax # 375-1547)

Does your student have health insurance? Yes No

If No, dial 1- 855-899-9600 for Vermont Health Connect info [https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action]

Please note: Confidential information about your student's health may be shared only with other school staff that need to know to protect your child's safety. School staff will keep this information private and will not share it with anyone else. If you have any concerns regarding this, please contact the school nurse.

Do you give permission for your student to have their teeth visually inspected, cleaned and have fluoride applied by a dental hygienist here at school? Yes No Comment_____

I give permission to exchange health information between my student's primary care provider, dentist, ophthalmologist and the school nurse, including immunizations, asthma, allergies, vision, hearing, dental and other medical concerns: Yes No Comment_____

Anyone forbidden with a court order? _____
***Please provide us with a copy of the court order (Name & Relationship to Student)**

IN CASE OF AN EMERGENCY INVOLVING MY STUDENT, WHEN I CAN NOT BE REACHED: I hereby give consent to transport my child for medical care and authorize the providers and hospital to give any reasonable and customary medical and health care deemed necessary at my expense. It is understood that I will be financially responsible for all emergency care.

Signature of Parent/Guardian _____ Date _____