Washington West Supervisory Union

2016-17 ANNUAL STUDENT HEALTH QUESTIONNAIRE

PART 1 PARENT OR GUARDIAN TO COMPLETE. Parent or guardian is encouraged to participate in the development of an Individual Healthcare Plan if needed.

STUDENT: Last	First	Middle	Sex ☐ M ☐ F	Grade	DOB

Parent or Guardian Name (Type or Print) ____________ Parent or Guardian Signature ____________ Date ____________

PART 2 COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD.

- Parent or guardian is responsible for providing the school with any medication, special food or equipment that the student will require during the school day.
- An additional medication permission form is required for any prescription medication given during the regular school day or during school-sponsored activities. Contact school health office for appropriate form.

ASTHMA (PLEASE ANSWER <u>ALL</u> OF THE FOLLOWING QUESTIONS) *Please continue to next section: Allergies*

1.Has the doctor, nurse or other health professional *EVER* said your child has asthma? ☐ Yes ☐ No ☐ Don't know/not sure

2.If *YES*, does your child STILL have asthma? ☐ Yes ☐ No ☐ Don't know/not sure

3.If *YES*, does your child have a current Inhaler prescription? ☐ Yes ☐ No ☐ Don't know/not sure

ALLERGIES ☐ **N/A** *Please continue to next section: Seizure Disorder*

☐ Bee Sting Specify Type: ____________

☐ Food List food(s): ____________

☐ Medication List meds: ____________

☐ Environmental/Other: ____________

Currently prescribed medications and treatment ☐ Oral antihistamine (Benadryl, etc.) ☐Epinephrine (EpiPen, Auvi-Q)

SEIZURE DISORDER ☐ **N/A** *Please continue to next section: Mental Health*

☐ Absence (staring, unresponsive) ☐ Complex partial ☐ Generalized tonic-clonic

Currently prescribed medications: ____________

Medications needed in school: ☐ No ☐ Yes List Med(s): ____________

MENTAL HEALTH ☐ **N/A** *Please continue to next section: Diabetes*

☐ ADHD ☐ Depression ☐ Anxiety ☐ Other: ____________

Currently prescribed medications: ____________

Medications needed in school: ☐ No ☐ Yes List Med(s): ____________

DIABETES ☐ **N/A** *Please continue to next section: Other Health Concerns*

☐ Type 1 ☐ Type 2

Currently prescribed medications: ____________

Medications needed in school: ☐ No ☐ Yes List Med(s): ____________

OTHER HEALTH CONCERNS ☐ **N/A** *Please continue to page 2*

Please Specify: ____________

Washington West Supervisory Union

2016-17 Annual Student Health Questionnaire

Student: Last First Middle	DOB

Wellness Check (in the last 12 months) [Required]

Provider: ______________________

Date: ________

Dental Visit (In the last 12 months) [Required]

Provider: ______________________

Date: ________ Sealants Applied ☐ Yes ☐ No

☐ *My child does not have a dentist;* ***Please*** *have the Tooth Tutor help find a dental home and conduct a free dental screening.*

Vision History [Optional]

☐ Glasses ☐ Contacts ☐ Non Correctable

Provider: ______________________

Date: ________

Hearing History [Optional]

☐ Hearing Aid ☐ Non Correctable

Provider: ______________________

Date: ________

Does your child have Health Insurance? ☐ Yes ☐ No *Please continue to next section: OTC Medication*

If **Yes,** which Carrier? ______________________

If ***No****, please call 1-800-250-8427 for more information* ***OR*** *info.healthconnect.vermont.gov/Medicaid*

Over the Counter Medication *Please continue to next section: Transport/Treatment*

I give permission for the school nurse or her/his designee to administer the following Over-the-Counter medications to my child (weight appropriate dose) **during the school day when necessary:**

Acetaminophen (generic Tylenol) ☐ Yes ☐ No Ibuprofen (generic Advil/Motrin) ☐ Yes ☐ No

Diphenhydramine (generic Benadryl) ☐ Yes ☐ No Antacid (generic Tums) ☐ Yes ☐ No

Consent for Emergency Transport/Treatment *Please continue to next section: Medical Information*

In case my child has a serious accident or sudden serious illness, I request the school to contact me. If not able to reach me, I authorize school personnel to seek emergency medical care, including transportation (at my expense) to a health care facility. I authorize the medical provider in charge to administer whatever emergency treatment is necessary at my expense.

______________________ Parent Printed Name ________ Date

______________________ Parent Signature

Parental Authorization for Release of Medical Information

Physician: ______________________

Dentist: ______________________

Other: ______________________

I give permission for release of information [please check appropriate box(es) below]:

☐ *From the school nurse to my child's physician/medical provider*

☐ *From my child's physician/medical provider to the school nurse*

regarding immunizations, well child exams and pertinent medical conditions.

______________________ Parent Printed Name ________ Date

______________________ Parent Signature