Harwood Union Unified School District

2017-18 ANNUAL STUDENT HEALTH QUESTIONNAIRE

Parent/Guardian Printed Name	PART 1 PARENT OR GUARDIAN TO COMPLETE. Parent or guardian is encouraged to participate in the development of an Individual Healthcare Plan if needed.							
Parent/Guardian Printed Name Parent/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 ALL 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 If YES, Asthma Action Plan Required ALLERGIES N/A Please continue to next section: Seizure Disorder Bee Sting Specify Type: Food List food(s): Please continue to next section: Mental Health Please continue to next section: Mental Health Please continue to next section: Mental Health Please continue to next section: Diabetes Don't knowly not sure Please continue to next section: Diabetes Diabetes Diabetes Please continue to next section: Diabetes					Sex	Grade	DOB	
Parent/Guardian Printed Name	Last	First		Middle				
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OTHER HEALTH CONCERNS	OTHER HEALTH CONCE	RNS 🗆 N/A		Please continue to	page 2 on	the <u>REVERS</u>	E SIDE	
Please Specify:	Please Specify:							
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Harwood Union Unified School District

2017-18 ANNUAL STUDENT HEALTH QUESTIONNAIRE

STUDENT:			DOB			
Last	First	Middle				
WELLNESS CHECK (IN TH	HE LAST 12 MONTHS) [REQUIRED]	DENTAL VISIT (IN THE LAST 12 MONTHS) [REQUI	RED]			
Provider:		Provider:				
Date:		Date:				
	_	Sealants Applied Yes No				
☐ My child does not have a dentist; PLEASE have the Tooth Tutor (Registered Dental Hygienist) help find a dental home and conduct a free dental screening.						
VISION HISTORY [OPTIO	NAL]	HEARING HISTORY [OPTIONAL]				
☐ Glasses ☐ Contacts ☐ Non Correctable		☐ Hearing Aid ☐ Non Correctable				
Provider:		Provider:				
Date:	_	Date:				
DOES YOUR CHILD HAV	'E HEALTH INSURANCE? 🔲 YES 🔲 NO	Please continue to next section: OTC Medicat	<u>ion</u>			
If YES, which Carrier?						
If No , please call 1-855-899-9600 for more information OR info.healthconnect.vermont.gov/Medicaid						
OVER THE COUNTER N	MEDICATION Please	continue to next section: <u>Transport/Treatment</u>				
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)						
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/Guardian	Printed Name Pa	rent/Guardian Signature	Date			
PARENTAL/GUARDIANSHIP 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/Guardian	Printed Name P	arent/Guardian Signature	Date			

ASHQ2017-18 Rev8 6/2017 Page 2 of 2