Harwood Unified Union School District

2018-19 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.** Contact school health office for additional information.

STUDENT: Last Name	First	Middle	Gender	Grade	DOB

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. Please contact the school health office with further details.
- An additional medication permission form is required for any medication given during the regular school day or during school-sponsored activities. Please contact the school health office for the 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): ____________

☐ Medication List meds: ____________

☐ Environmental/Other: ____________

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

If Epinephrine is prescribed, an Allergy Action Plan Required.

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 on the REVERSE SIDE***

Please Specify: ____________

Harwood Unified Union School District

2018-19 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: __________

☐ *I am interested in having the Tooth Tutor provide preventive services at school (e.g., cleaning, fluoride treatments or sealants)*

☐ *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 [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 1-855-899-9600 for more information **OR** info.healthconnect.vermont.gov/medicaid*

SCHOOL SUPPLIED OVER THE COUNTER MEDICATIONS *Please continue to next section: Transport/Treatment*

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

Medication		Medication	
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/Guardian Printed Name ____________________ Parent/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*

related to immunizations and medical conditions that may impact my child's safety and success at school.

Parent/Guardian Printed Name ____________________ Parent/Guardian Signature ____________________ Date __________