Frederick H. Tuttle Middle School

ANNUAL HEALTH UPDATE & EMERGENCY AUTHORIZATION FORM

School year: _____ Student's Grade (Circle): 6, 7, 8

Student Name: _____ Birthdate: _____

STUDENT'S MEDICAL HISTORY:

My child has had a comprehensive annual well-care visit*in the past year. **Yes** (date): _____ **No**_____

***A comprehensive well-care visit (physical) is not an appointment for sickness, injury, or chronic health needs.**

Provider's Name: _____ Phone: _____

Please provide an updated copy of your child's immunization record.

My child has had a dental exam in the past year. **Yes** (Date): _____ No_____

Dentist's Name: _____ Phone: _____

Has your child been to any **other** health care provider in the past 12 months? **_____Yes _____No**

(i.e. optometrist, ENT, allergist, psychiatrist, any other)

- If yes, name of provider(s): _____
- Reason/outcome/treatment: _____
- Date of most recent visit: _____

(Please use additional paper if more space is needed).

Does your child have health insurance? _____Yes _____No If No, **dial 1-855-899-9600** for Vermont Health Connect or visit https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action

ASTHMA: Has a doctor, nurse or health professional EVER said that your child has asthma? **___Unsure ___Yes ___No**

If yes, does your child STILL have Asthma? **___Unsure ___Yes ___No**

If yes, please provide school with an updated **Asthma Action Plan.** Type: _____

The following over-the-counter medications are used in the health room. Please cross out those which you **DO NOT** want your child to have during the course of routine visits to the health room and sign below.

BACITRACIN OINTMENT	HYDROCORTISONE CREAM 1% (anti-itch)	IBUPROFEN (ADVIL)
ACETAMINOPHEN (TYLENOL)	COUGH DROPS	FIRST AID CREAM
CALAMINE LOTION GEL	ANTACID TABLETS	ALOE VERA
INSECT STING RELIEF	BENADRYL **(FOR EMERGENCY IF PARENT CANNOT BE CONTACTED)**	

I give my permission for school staff to administer the medications and products listed above. I acknowledge that I am responsible for making after-school personnel aware of my child's health care needs and providing the personnel with necessary medication and treatment procedures/instructions separately from this form. I acknowledge that if my child is injured or ill at school and emergency care is necessary, school staff will seek medical care, while trying to reach me or other emergency contact(s).

_____ / _____

Signature: Parent or Guardian **Date**

_____ / _____

Printed Name: Parent or Guardian **Relationship to Student**

--PLEASE COMPLETE THE OTHER SIDE--

Frederick H. Tuttle Middle School

ANNUAL HEALTH UPDATE & EMERGENCY AUTHORIZATION FORM (continued):

ALLERGIES: Requiring Epinephrine ___No ___Yes

Allergic to: _____

Treatment: ☐ Epinephrine ☐ Benadryl ☐ Other_____

OTHER ALLERGIES/SENSITIVITIES/INTOLERANCES: Not Requiring Epinephrine ___Yes ___No

List: _____

FOOD AVOIDANCE (non-allergy**): ___No ___Yes- List:** _____

DIABETES: ___No ___Yes Type: _____ Treatment: _____

SEIZURES/EPILEPSY: ___No ___Yes Type: _____ Treatment: _____

BLEEDING DISORDER: ___No ___ Yes _____

EAR/HEARING PROBLEMS: ___No ___Yes

Condition: _____

Treatment/Date_____

CORRECTIVE LENSES (GLASSES/CONTACTS): ___No ___Yes

Glasses/contacts (please circle) worn for: ☐ Distance ☐ Near ☐ All the time

Condition: _____

Date of last vision exam: _____

Eye Specialist: _____

HEART PROBLEM: ___No ___ Yes _____

HIGH BLOOD PRESSURE: ___No ___Yes _____

MENTAL HEALTH CONDITION: ___No ___Yes _____

Treatment:_____

Provider:_____

MUSCULAR WEAKNESS OR PARALYSIS: **___No ___Yes** _____

MIGRAINE HEADACHES: ___No ___Yes _____

Treatment: _____

HOSPITALIZED/RECENT SERIOUS ILLNESS, INJURY, ACCIDENT OR SURGERY ___No ___Yes _____

Date(s): _____

ANY CONDITIONS/PROBLEMS (not listed above**): ___No** _____**Yes** _____

_____

_____

PLEASE CONTACT THE SCHOOL NURSE TO PROVIDE MORE INFORMATION FOR ANY OF THE ABOVE CONDITIONS.

MEDICATIONS* TAKEN ON A REGULAR BASIS *(please use additional paper if needed)*:

Medication	Dosage	Time(s) of day taken	Reason(s)

If medication is to be taken at school:

***Prescription* medication** needs written health care provider's permission and written parental permission**.**

***Non-prescription* medication** needs only written parental permission**.**

***All* medication** needs to be brought to the health office by an adult, in the original, labeled container**.**

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