Pittsfield School District
Strong Community•Strong Schools

STUDENT HEALTH FORM

Parent or Guardian to Complete

Student's Name: Last:	First:	Middle:	Sex: M or F	DOB:

School Year:	Grade Level:	Teacher Name:

Home Phone:	Father's Work/Cell Phone:	Mother's Work/Cell Phone:

Parent/Guardian(s) Name(s):

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. Check with the school nurse to obtain correct medication and procedure forms.

Over the counter medications available from School Health Office: *All doses given per label recommendation, according to age and weight. Please check the ones you give permission for your child to receive at school.*

☐ ACETAMINOPHEN (Tylenol) ☐ CALAMINE LOTION ☐ COUGH DROPS

☐ VASELINE/LIP BALM (Chapped lips) ☐ TRIPLE ANTIBIOTIC OINTMENT ☐ TUMS

☐ BENADRYL (Allergic reaction) ☐ LIDOCAINE (Burn) ☐ IBUPROFEN (Advil)

☐ SUNSCREEN ☐ HYDROCORTISONE CREAM (Itching/Rashes)

☐ Aloe (Sunburns)

I agree by signing this statement that I will not hold liable the school nurse, deans, or designee, in assisting my child in taking the above named non-prescription medicine.

Student: ___________________________________ Parent/Guardian (Print): ____

Parent/Guardian Signature: ____ Date: _________________________

☐ **I *DO NOT* give permission to administer medication at school**

My child has a medical condition that may affect his or her school day: ☐ **YES** ☐ **NO** *(Please Indicate Below)*

ALLERGIES

Allergy Type:

☐ Bee Sting

☐ Medication List medication(s): ____

☐ Food List food(s): ____

☐ Other List Other: ____

Reactions: ☐ Coughing ☐ Hives ☐ Rash ☐ Difficulty Breathing ☐ Local Swelling ☐ Wheezing

Will supply epinephrine at school ☐ YES ☐ NO *If yes, please complete the Health Management form*

ASTHMA

Triggers: ☐ Exercise ☐ Environmental ☐ Other (list) ____

Physical Education Restrictions: ☐ None ☐ Self-limits ☐ Other ____

Symptoms or reactions:

☐ Chest tightness, discomfort or pain ☐ Difficulty breathing ☐ Throat itch, tightness or soreness

☐ Coughing hoarseness ☐ Wheezing ☐ Other ________________________________

Date of last hospitalization related to asthma: ______________________________

Will supply inhaler at school ☐ YES ☐ NO *If yes, please complete the Health Management form*

CONTINUE ON REVERSE

DIABETES

Currently prescribed treatment to be used *IN SCHOOL:*

Insulin: ☐ Syringe ☐ Pen ☐ Pump ☐ Pod ☐ Blood sugar testing ☐ Glucagon ☐ Oral medication(s)

SEIZURE DISORDER

Type of seizure:

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

☐ Other (explain): ____

Date of last seizure: ______________________ **Length of seizure:** ______________________

MENTAL HEALTH CONCERNS

☐ Depression ☐ Anxiety ☐ Bi-Polar ☐ ADD/ADHD ☐ Autism

Other: ____

VISION/HEARING CONDITIONS

☐ Contacts ☐ Glasses ☐ Hearing Aids ☐ Other: ______________________

PHYSICAL EDUCATION RESTRICTIONS

☐ NO ☐ YES (Please explain) ____

OTHER CONDITIONS OR SPECIAL PROCEDURES

Please explain: ____

MEDICAL RELEASE

I authorize the school's representative(s) to transport, request and authorize treatment for my son/daughter in the event of an accidental injury or illness. I agree that I will not hold this person(s) liable while he/she is acting in accordance to these directions. Copy of this authorization is of equal validity as original document.

Please check the box that applies: ☐ **YES** ☐ **NO**

______________________________ ______________________

Parent/Guardian Signature Date

Parent/Guardian Name (Please print): ______________________________

PROVIDER EXCHANGE PERMISSION

I authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form and any medically relevant concern. *This authorization will be in place until or unless you withdraw it.* ***You may withdraw your authorization at any time by contacting your child's school.*** *When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.*

Please check the box that applies: ☐ **YES** ☐ **NO**

______________________________ ______________________

Parent/Guardian Signature Date

Parent/Guardian Name (Please print): ______________________________

Physicals and Immunizations: *All new registrations to the district must provide a copy of your child's most recent physical exam. Immunization records on file must be current in order to be in compliance with the state law.* Your child may not be allowed to begin school or may be excluded from attending until the school nurse receives them. **Please refer to the Department of Health and Human Services at *www.dhhs.nh.gov* or by calling 1-800-852-3345 ext. 4482 for more information.**

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HEALTHCARE MANAGEMENT

Parent or Guardian to Complete

Student's Name: Last:	First:	Middle:	Sex: M or F	DOB:

School Year:	Grade Level:	Parent/Guardian(s) Name(s):

MEDICAL PROVIDER(S)

Physician Name: ______________________________

Address: ______________________________ Phone: ______________

Dentist Name: ______________________________

Address: ______________________________ Phone: ______________

Student's Insurance Company: ☐ No Health Insurance ☐ Medicaid Carrier: ______________

☐ Private/HMO: Name of Company: ______________________________

MEDICATIONS

Medications to be given as needed *IN SCHOOL:* (rescue inhaler, epi pen, etc…)

Medication Name: ______________________________ Dose: ______________

What does this medication treat? ______________________________

Medication Name: ______________________________ Dose: ______________

What does this medication treat? ______________________________

Medications scheduled *IN SCHOOL:* (to be taken at a set time on a regular schedule)

Medication Name: ______________________________ Dose: ______________

What does this medication treat? ______________________________

Medication Name: ______________________________ Dose: ______________

What does this medication treat? ______________________________

Medications *TAKEN AT HOME:*

Medication Name: ______________________________ Dose: ______________

What does this medication treat? ______________________________ Time Given ______________

Medication Name: ______________________________ Dose: ______________

What does this medication treat? Time Given

Please Note: No medication will be given at school until the school nurse receives the appropriate Medication Permission Form and the medication ***in the original container, labeled with the student's full name*.** Medications that are prescribed by a provider will require an order from the provider. *All medication, prescription or over the counter, must be transported to and from school by a parent/guardian and will be kept in the Health Services office. Certain emergency medications may be carried on the person only with the medical provider's written consent.*

Non-prescription Medication: All non-prescription medication should be delivered to the school nurse directly. It should be in the original container, should include the student's name, name of medication, and reason and times it should be given. The school nurse MUST receive the appropriate Medication Permission form for any over the counter medications that are not supplied by the Health Office (*medications that are supplied can be found on the Medical History form*).