M.S.A.D #72

STUDENT HEALTH INFORMATION**

Nancy Boucher RN, BSN 207-935-2401

Student Name_____ **Birth Date**_____

Teacher_____ **Grade** _____

**If any health information is of a sensitive nature, please contact the school nurse.

1. **List Allergies to foods:** _____

   a. **Type of Reaction:** ❑ Local ❑ Gastric problems ❑ Life Threatening
   b. **# of reactions to date:** _____
   c. **What causes reaction?** ❑ Eating foods ❑ Touching foods ❑ Smelling foods
   d. **How quickly do the reaction signs appear**: ❑ seconds ❑ minutes ❑ hours ❑ not sure
   e. **Treatment Required**: ❑ Benadryl dosage _____ (please supply to school)
      ❑ EpiPen ❑ Adult dose ❑ Junior dose (please supply to school)
      ❑ No Treatment
   f. **I give consent to share, with the classroom, that my child has a life-threatening food allergy:**
      ❑ Yes ❑ No

   List Allergies to medications: _____

   a. **Type of Reaction**: ❑ Local ❑ Life Threatening
   b. **Treatment Required**: ❑ Do not administer

   List Allergies to bee stings/insects/animals: _____

   a. **Type of Reaction**: ❑ Local ❑ Life Threatening
   b. **# of reactions to date:** _____
   c. **How quickly do the reaction signs appear?**❑ seconds ❑ minutes ❑ hours ❑ not sure
   d. **Treatment Required**: ❑ Benadryl dosage _____ (please supply to school)
      ❑ EpiPen ❑ Adult dose ❑ Junior dose (please supply to school)
      ❑ Ice only ❑ No Treatment

2. **Does your child have Asthma?** ❑ Yes ❑ No
   a. **If yes, does your child miss school due to asthma symptoms?** ❑ Yes ❑ No
   b. **Do your child's asthma symptoms require unscheduled visits to doctors and/or emergency rooms?** ❑ Yes ❑ No
   c. **If you answered "yes" to the above two questions *please call the school nurse (935-2401) to develop a plan for your child.***

3. **Does your child have a seizure disorder?** ❑ Yes ❑ No
   When was your child diagnosed with the seizure disorder? _____
   Type of Seizure: ❑ Tonic-clonic (grand mal) ❑ Absence ❑ Other _____
   What might trigger a seizure in your child? _____
   Are there any warning and/or behavior changes before the seizure occurs? ❑ Yes ❑ No
   When was your child's last seizure? _____
   What seizure medication(s) does your child take? _____

   Please call the school nurse (935-2401) to develop a plan for your child.

Please Complete Reverse and Sign ➢

4. **Does your child have diabetes?** ❑ **Yes** ❑ **No**
   If yes, please call the school nurse (935-2401) to develop a plan for your child.

5. **Does your child have ADD or ADHD?** ❑ Yes ❑ No
   If Yes, does your child take medication? ❑ Yes ❑ No
   List medication, dosage and time received: _____

6. **List any heart conditions?** _____
   Does your child have any physical restrictions? ❑ Yes ❑ No
   If yes, list restrictions and provide doctor statement: _____
   _____

7. **Any hospitalizations, surgeries, or orthopedic injuries this past year?** ❑ Yes ❑ No
   If yes, please explain: _____
   _____

8. **Does your child wear glasses or contacts?** ❑ Yes ❑ No
   Has your child had any eye surgeries? ❑ Yes ❑ No
   List any eye conditions: _____
   When was your child's last eye doctor assessment? _____

9. **Does your child wear Hearing Aides?** ❑ Yes ❑ No
   Has your child had ear tubes? ❑ Yes currently ❑ Yes in the past ❑ No

10. **List all other health conditions/problems, such as gastro-intestinal issues, kidney issues, mental health issues, skin/eczema issues, any form of cancer, neurological issues:** _____
    _____
    _____

11. **List any prescription and non-prescription medications your child takes that you have not already listed:** _____
    _____

List Health Care Providers:

Primary Physician_____ **Dentist**_____

Ear Specialist _____ **Eye Doctor**_____

Other Specialists_____ **Counselor**_____

DHHS Caseworker_____ **Hospital of Choice:** ❑ Bridgton

❑ Memorial - No Conway NH

❑ **No health issues at this time.**

In case of accident or illness, I request that the school contact me. If the school is unable to reach me, I hereby authorize the school to make whatever arrangements deemed necessary to provide care for my child.

_____ _____

Parent/Guardian Signature **Date**