Sharon Elementary School - Emergency & Health Information Form

Child's Name:_____**Grade**:_____**DOB**:_____

Contact information, (who the nurse should call for health concerns).

Mom or Guardian#1_____
Home#_____ Cell#_____Work #_____
Email_____Days & hours at work_____
What days of the week does your child reside with you:_____

Dad or Guardian #2_____
Home#_____ Cell#_____Work #_____
Email_____Days & hours at work_____
What days of the week does your child reside with you:_____

Emergency contact (1):_____ Phone:_____
Emergency contact (2)_____Phone:_____
(Contact other than parent or guardian).

Current Health Concerns (eg, asthma, allergies, ADHD)_____
Is your child on any medications? ____No _____Yes. If yes, list medication below:

Medication_____Dose_____ Time given_____
Medication_____Dose_____ Time given_____
Medication_____Dose_____ Time given_____

If your child has asthma, does he/she use an inhaler? ____Yes ___ No
What triggers an asthma attack? (eg, exercise, cold/flu)_____
How often is the inhaler typically used? (eg. with exercise, daily, weekly, monthly, seldom)
_____.

Allergies and symptoms:_____.
Does your child have an Epi Pen? _____No ____Yes

Permission to Receive Over-the-Counter Medications
My child has permission to receive the following medications at school (check all that apply).
_____Acetaminophen (e.g. Tylenol)
_____Ibuprofen (e.g. Advil)
_____ Antibiotic Ointment (e.g. Polysporin for minor cut/scrape)
_____Calamine lotion (for insect bite or localized rash)
_____Antihistamine (e.g. Benadryl or Claritin for allergies or allergic reaction)
_____Cough drops (for minor cough without fever)
_____Antacid (e.g. Tums for upset stomach)
_____Hydrocortizone cream (e.g. Cortaid for localized rash)

I

PLEASE TURN OVER I understand that when the School Nurse is not present, medications are given by non-medical personnel trained by the School Nurse in medication administration.

Signed_____Date_____
Parent/guardian signature

After School Care:
Picked up after school_____Rides the bus #_____ Combination bus & picked up_____
Participates in after school program (One Planet) **No____Yes**-which days**: M T W TH F**

Immunization Information:
If your child had immunizations over the summer or new to Sharon Elementary School**, please bring a copy of your immunization records or fax them to school: 802-763-2056.**

Health Coverage
Child's Doctor: _____ Phone:_____
Do you have medical insurance? _____ If so, name of insurance_____
Approximate date of last doctor's visit_____

Child's Dentist:_____Phone:_____
Do you have dental insurance? _____ If so, name of insurance_____
Approximate date of last exam_____

Release of Medical Information

I give permission for _____ to release
Doctor's or Medical Facility name

information regarding immunizations, medications and health/dental concerns to the School Nurse at Sharon Elementary School.

Signed_____ Date_____
Parent/guardian signature

Permission for Treatment and/or Transportation

In the event that your child has a serious illness or injury the school will make every effort to reach a parent. If unable to reach me, I hereby authorize the school personnel to contact my child's physician and/or seek emergency medical care, including transportation to a medical facility. I authorize the physician and emergency room staff to provide care that is considered necessary.

Signed_____ Date_____
Parent/guardian signature