

# Windham Southeast Supervisory Union 2021-2022 Annual Health Form

**BAMS** 109 Sunny Acres **BUHS** 131 Fairground Rd **WRCC** 80 Atwood St.  
Brattleboro, VT 05301

Student Name:	DOB:	Pronoun:	Grade:
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## Emergency Contact Information

Parent/Guardian #1: email:	Home Phone: Cell Phone:	Place of Employment: Work Phone:
Parent/Guardian #2: email:	Home Phone: Cell Phone:	Place of Employment: Work Phone:
Emergency Contact#1: Emergency Contact #2:	Relationship: Relationship:	Phone: Phone:

## Medical Information and Health Questions

List and describe any **HEALTH PROBLEMS, ILLNESS, DISABILITY** (seizures, ADD, ADHD, anxiety, cardiac, concussions) the school should be aware of:

<b>ALLERGIES</b> (food, venom, medications, seasonal) and symptoms. If you child has food allergies, please list specific food restrictions:	<b>ASTHMA</b>	Y	N
	Has a doctor, nurse, or other health professional EVER said that you child has ASTHMA?	<input type="checkbox"/>	<input type="checkbox"/>
	If YES, does your child STILL have ASTHMA?	<input type="checkbox"/>	<input type="checkbox"/>
	If YES, does your child have an up-to-date VT Asthma Action Plan?	<input type="checkbox"/>	<input type="checkbox"/>
	Will your child require the use of an inhaler during school?	<input type="checkbox"/>	<input type="checkbox"/>
	Will your child need to take medication during school hours? If yes, medication name:	<input type="checkbox"/>	<input type="checkbox"/>

Please list any **MEDICATIONS** your child takes regularly: \_\_\_\_\_

Doctor/Nurse Practitioner:	Well Child Exam within the last year?	Yes	No
Dentist:	Appointment within the last year?	<input type="checkbox"/>	<input type="checkbox"/>

Please list **OTHER Medical Providers**: \_\_\_\_\_

Does your child have Health Insurance? For information on Vermont Insurance ( <a href="http://vermonthealthconnect.gov">vermonthealthconnect.gov</a> or 1-855-899-9600)	Yes	No
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**Please review the list below and please place a check next to the over the counter medications that you approve for administration to your child while at school (as needed):**

Tylenol (Acetaminophen)
  Motrin/Advil (Ibuprofen)
  Antacid (Calcium Carbonate)
  Benadryl (Diphenhydramine)
  Sunscreen
  Insect Repellent

## SIGNATURES NEEDED-Please Sign Both

**In Case of Emergency:** In case of accident or acute illness I request that the school contact me. In an emergency, emergency personnel can be contacted. If the school is unable to reach me, I hereby authorize the school to call the health care provider indicated and to follow his/her instructions. If it is impossible to contact the provider, the school may make whatever arrangements necessary.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Release of Information:** I give permission for school nurse to send/ receive confidential medical information to ALL my child's Health Care Providers

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

