MSAD #70 - Annual Health Update
School Nurse - Erin Mitchell, RN 532-9228
School Year 2021-2022

Name: _____ Date of Birth: _____ Grade: _____

Mother's/Guardian's Name: _____ Phone Number: _____

Father's/Guardian's Name: _____ Phone Number: _____

Primary Care Provider's Name: _____ Phone Number: _____

Dentist's Name: _____ Phone Number: _____

Emergency Contact Name: _____Relationship: _____ Phone Number: _____
Emergency Contact Name: _____Relationship:_____Phone Number: _____

Medical History: Please check any of the medical issues that apply to your child (current or past):

____ Asthma (inhaler: yes no)	____ Diabetes	____ Kidney Disorder
____ ADHD	____ Ear/Hearing Problems	____ Muscular Dystrophy
____ Blood Disorder	____ Epilepsy/Seizure Disorder	____ Migraine Headaches
____ Cancer	____ Eye/Vision Problem	____ Physical limitations
____ Cystic Fibrosis	____ Heart Disease/Defect	____ Prone to Headaches
____ Cerebral Palsy	____ Hemophilia	____ Prone to Stomach aches
____ Constipation	____ Anxiety	____ Depression

____ Other _____

____ Glasses ____ Contacts ____ Hearing Aids ____ Feeding tubes
____ NONE Explain: _____

Please list any significant injuries within the past year (sprain, fractures, surgeries, hospitalizations, etc.)

_____

Allergies: (PLEASE MARK ONE OF THE FOLLOWING)
____ NO ALLERGIES

____ Food (Please list) _____

____ Environmental (Please list) _____

____ Medication (Please list) _____

____ Bees/Wasps/Hornets _____

Reaction: ____ Local redness/Swelling ____ Hives ____ Difficulty Breathing ____ Other
Treatment: ____ Benadryl ____ EpiPen ____ Other

Medication:
Does your child take medications at home? ____ Yes ____ No
Please list any medications and over the counter (vitamins, herbal supplements, etc.) It is important that we know this at school so that we may be aware of any side effects.

_____

Does your child need to take medication at school? ____ Yes ____ No

Please list the name of the medication, dosage, time, and reason medication is to be given:

_____

If your child will be taking medication during school hours, school policy requires that the medication be brought into the school nurse in the original container from the pharmacy. A school medication form is required with parent and prescribing provider signatures. Parents are responsible for getting medications directly to the school nurse and completing the required paperwork. No medications are allowed to be transported on the bus.

Medical Treatment While in School:

It is understood that the school nurse or medically trained designee (secretary, health aid, principal) will provide students with the following: **(Please check the boxes you would like your child to receive)**

- ☐ Tylenol (for menstrual cramps, dental pain, headaches, general discomfort, fever)
- ☐ Basic first aid treatment
- ☐ Moisturizing lotion / or soaps for dry chapped skin
- ☐ antacid / tums, pepto bismol
- ☐ orajel for mouth pain
- ☐ petroleum based jelly and/or vaseline for chapped lips
- ☐ Triple Antibiotic Ointment (cuts / Scrapes)
- ☐ ice packs / hot packs
- ☐ hydrocortisone cream, calamine lotion (itching skin)
- ☐ saline eye drops (eye irritation)

By signing below, as the parent/guardian, I am giving permission for my child to receive any of the checked medications listed above during school hours.

Parent/Guardian: _____

I authorize the MSAD 70 school nurse or delegated staff member to contact persons named on this form. If I or the emergency contacts I have listed are not available, I authorize the MSAD 70 staff to take whatever action is deemed necessary in their judgment for the health of my child. I authorize the physician or emergency room personnel to render treatment to my child as may be necessary in an emergency.

I understand that we as parents or guardians are responsible for providing transportation in case of our child's illness or accident, including costs of an EMS ambulance if necessary. I am aware that the school staff may have to arrange transportation for my child in a serious situation.

I authorize that the school nurse may contact my child's physician/health care provider(s) for pertinent health related information to be received and given about my child.

Parent/Guardian Signature:_____ **Date:**_____

The State of Maine requires schools to monitor each student's health throughout his/her school years. Part of the monitoring is to ensure up to date immunizations, vision and hearing screenings. The nursing office will notify parents of any abnormal findings/concerns.