

East Montpelier Elementary School - Annual Health Questionnaire
School Year 2009-2010

This form will be kept in the Student's Health Record and used as a reference throughout the year. All information is confidential and will be shared only with staff that needs to know. Please answer completely. For the sake of confidentiality, you may choose to mail this questionnaire to the school or place it in an envelope addressed to Elizabeth Wirth, School Nurse.

Student's Name: _____ **Age:** _____ **Grade:** _____

Date of Birth: _____ **Parent/Guardian(s) Name(s):** _____

Yes No **Allergies:** If yes, please check and describe below:

_____ **LIFE-THREATENING ALLERGIES** _____
_____ food allergies _____
_____ medication allergies _____
_____ environmental or other _____

Yes No **Seizures:** If yes, please describe _____

Yes No **ADD or ADHD:** _____

Yes No **Asthma:** _____

Yes No **Diabetes:** _____

Yes No **Eyeglasses/Contacts:** _____

Yes No **Eye problems:** _____

Yes No **Hearing or ear problems including hearing aides, frequent infections, tubes:** _____

Yes No **Other health conditions that the school nurse should know about:** _____

Yes No **Medication(s) taken at home :** _____

Yes No **Medication(s) needed at school:** _____

(New medication forms must be completed each school year. Get forms from the school nurse or website.)

Yes No **Has your child had any recent life events that might impact him/her socially and /or emotionally?** (i.e. loss of a relative, military deployment of a family member, family separation, etc.)
If yes, please explain: _____

Yes No **Has your child received counseling or psychological services?** If yes, please explain: _____

Yes No **Would you like to meet with the school counselor to discuss these events and/or your child's success at school?** If yes, the school counselor will contact you.

Yes No **Does your child have health insurance?** *(If no, call 1-800-250-VHAP for lower cost insurance.)*

I give permission for the school nurse or her designee to give the following to my child (in an age & weight appropriate dose) **during the school day when necessary.**

Yes No **Acetaminophen** (generic Tylenol)

Yes No **Ibuprofen** (generic Advil, Motrin)

Yes No **Weekly Fluoride Mouthrinse** (Grades 1 - 6 only. Additional info on school website.)

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

RELEASE OF MEDICAL INFORMATION

Please list your child's:

Doctor: _____ Tel: _____ Visit in last year? Yes No

Dentist: _____ Tel: _____ Visit in last year? Yes No

Other provider: _____ Tel: _____

Other provider: _____ Tel: _____

(such as WIC, social worker, counselor, therapist, other specialists or clinics)

I give my permission for Elizabeth Wirth, RN, the school nurse at East Montpelier Elementary School, to contact the health care providers listed above concerning _____'s health conditions, medications, and immunizations.

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