St. Albans Town Educational Center

ANNUAL HEALTH UPDATE & EMERGENCY AUTHORIZATION FORM

PURPOSE: To enable parents/caregivers to AUTHORIZE emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached. Upon completion, parents/ caregivers must return this form to the school. The original form and any copies thereof may be used to identify the medical options of the undersigned parent. The original form stays with the school nurse.

School District _____ School Building _____ Home Room Teacher _____ Grade _____

Student's Full Name

Last _____ **First** _____ **Middle initial** _____

Doctor's Name:	Phone
What was the date of your child's last comprehensive annual well-care visit* received in their medical home? Date: _____	
Dentist's Name:	Phone
What was the date of your child's last dental exam received in their dental home? Date: _____	

*** A comprehensive well-care (physical) visit is not an appointment for sickness, injury, or chronic health need.**

STUDENT'S MEDICAL HISTORY:

- **ALLERGIES: : (please describe)** _____
  - **Serious Allergy - Requires epinephrine**

  _____ Yes _____ No _____ Don't know/not sure
- **ASTHMA:** Has a doctor, nurse, or other health professional EVER said that your child has asthma?

  _____ Yes _____ No _____ Don't know/not sure
  - If yes, does your child STILL have asthma?

  _____ Yes _____ No _____ Don't know/not sure
- **DIABETES? Yes ____ NO ____**
- **SEIZURES? Yes ____ NO ____**
- **MEDICATIONS taken on a regular basis (Please explain):**

_____

- **USE CORRECTIVE LENSES? YES_____ NO _____ HEARING AIDS? YES _____ NO _____**

Does your child have health insurance? Yes ____ No ____ If No, **dial 1- 855-899-9600** for Vermont Health Connect info [https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action]

IN CASE OF AN EMERGENCY INVOLVING MY CHILD, WHEN I CAN NOT BE REACHED: I hereby give consent to transport my child for medical care and authorize the providers and hospital to give any reasonable and customary medical and health care deemed necessary at my expense. It is understood that I will be financially responsible for all emergency care.

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

I give my permission for the school nurse or ***Tooth Tutor*** *(if available) to communicate with my dental provider:* ☐ **Yes** ☐ **No**

I give permission to exchange health information between my child's primary care provider and the school nurse, including vision and hearing screening information: ☐ **Yes** ☐ **No**

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

Please indicate if student has had or is currently under treatment for any of the following conditions:

_____**BLEEDING DISORDERS**
_____**EAR/HEARING PROBLEMS**
_____**HEART PROBLEMS**
_____**HIGH BLOOD PRESSURE**
_____**HOSPITALIZED FOR SERIOUS ILLNESS, SURGERY OR ACCIDENTS?** _____
_____

_____ **MENTAL HEALTH CONDITION and treatment (Please explain):**
_____
_____
_____**MUSCULAR WEAKNESS OR PARALYSIS**
_____**MIGRAINE HEADACHES**
_____**OTHER allergies: (Please list)** _____
_____

PLEASE ADD ANY PROBLEMS NOT LISTED _____
Notes:

Sibling Information:

Last Name	**First Name**	**Grade**

Permission for Over the Counter Medications (OTC)

My child has permission to receive the following medications at school according to the instructions on the manufacturer's label:

Acetaminophen/Tylenol	YES ___ NO ___
Ibuprofen/Advil	YES ___ NO ___
Cough drops	YES ___ NO ___
Benadryl	YES ___ NO ___
Tums/Antacid	YES ___ NO ___
Caladryl Clear/Anti-itch lotion	YES ___ NO ___
Antibiotic ointment/Bacitracin	YES ___ NO ___

*Moisturising lotion/Vasaline/Aloe gel may be used unless otherwise noted

School personnel who are responsible for my child may apply or assist with the application of products supplied by me (the parent/guardian) according to the written manufacture's label for children.

SUNSCREEN: YES ___ NO ___ **INSECT REPELLENT:** YES ___ NO ___

_____ _____ _____
Signature – Parent or Guardian **Relationship to student** **Date**