Sanford School Department
Annual Health Record

Student's Name_____
Birth date: ____/____/____ Female___ Male____
School: _____ Grade:_____
Teacher/Program/LC:_____

Dear Parent/Guardian:

Please complete this form and return to school as soon as possible.
Parent/Guardian: _____ Phone numbers: _____/_____
Parent/Guardian: _____ Phone numbers: _____/_____
Emergency Names: Persons authorized for student when ill or can act in an emergency when parents are unavailable.
Name: _____ Phone Number: _____
Name: _____ Phone Number: _____

HEALTH CONCERNS: ▢ **NO HEALTH CONCERNS**

ALLERGIES
Does your child have any life threatening Allergies: Yes ▢ No ▢

Food ▢: _____Medications ▢ :_____:Bee stings ▢**:_____**Seasonal/ Other▢:_____

Does your child's allergy require an Epi-pen? Yes ▢ No ▢
***If an anaphylaxis history, an allergy action plan must be provided**

SEIZURES
Has your child ever been diagnosed with a seizure disorder Yes ▢ No ▢ ***If yes, an seizure action plan must be provided**

ASTHMA
Has your child ever been diagnosed by a medical provider as having asthma that requires an emergency inhaler?
Yes ▢ No ▢ ***If yes, please provide school nurse with asthma plan and medication**

DIABETES
Has your child been diagnosed with Diabetes? Yes ▢ No ▢ ***If yes, please provide school nurse with road map and supplies**

ADHD/ADD
Has your child been diagnosed by a medical provider as having ADD/ADHD? Yes ▢ No ▢
Diagnosed by Provider: Name_____
Medication (name/dose/time): _____

Has your student been medically diagnosed with Anxiety or Depression Yes ▢ No ▢

Has your child been diagnosed with Migraines? Yes ▢No ▢ Treatment: _____

▢ASD	▢Bowel/Bladder	▢Bleeding disorder
▢ Heart condition	▢ Vision Problems	▢Hearing Problems
▢other_____	▢other_____	▢ Hospitalization in the last year Yes No

I _____ give permission for my child, _____, to be treated at Southern Maine Health Care of Sanford, in the event of an emergency. It will be my responsibility to have him/her transferred to another facility if I choose.

AUTHORIZATION TO RELEASE HEALTH RECORDS

I HEREBY AUTHORIZE MY CHILD'S HEALTH CARE PROVIDER AND PREVIOUS SCHOOL TO RELEASE MY CHILD'S MOST RECENT PHYSICAL, IMMUNIZATION AND OTHER PERTINENT HEALTH INFORMATION TO SANFORD SCHOOL FOR COMPLETION OF HEALTH RECORDS. THIS AUTHORIZATION IS VALID WHILE STUDENT IS ENROLLED IN SANFORD.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

PLEASE FLIP FOR SECOND PAGE

SANFORD SCHOOL DEPARTMENT **Student's Name_____**
ANNUAL HEALTH RECORD

Students Doctors:

Medical Doctor_____Last Seen_____Results_____
Dentist_____Last Seen_____Results_____
Eye Doctor_____Last Seen_____Results_____
Health Insurance_____ Subscriber: _____ Policy #: _____

Medications:
List **ALL** medications that the student takes every day or when needed. Consent is **REQUIRED** for **ALL** medications taken at school, including over the counter medications. The consent must be signed by both the Health Care Provider and a Parent. A new consent is needed for each school year. Forms are available in the health office on online.

Medication Name	Dose	How Often/Time	Reason for taking

I give permission for the school to give my child the following as needed: (frequency per standing orders an age based and weight-based dosages):

❑ **Tylenol (acetaminophen)**	❑ **Motrin/Advil (ibuprofen)**	❑ **Benadryl**
❑ **Tums (500 mg tabs)**	❑ **Cough Drops (Gr. 4-12 only)**	

Parent Signature : _____ Date: _____

4/9/19