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 number: _____
Parent/Guardian: _____ Phone number: _____
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 ▢

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 SIDE

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_____

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**	❑ **Cough Drops**	❑ **Icy Hot**

Parent Signature : _____ Date: _____

******** FOR SANFORD REGIONAL TECHNICAL CENTER STUDENTS ONLY *********

It is highly recommended that all Sanford Regional Technical Center students are covered by accident insurance. Student may purchase accident insurance affordably through their partner school. Please indicate your child's insurance information below.

▢ My child is not currently covered by health/accident insurance. I understand that I am responsible for charged medical care if my child is injured through participation in their program at SRTC.

▢ My child is covered by health/accident insurance policy:

Insurance Company _____ Subscriber: _____
Policy Number: _____

_____ _____

Parent/Guardian Signature Date