**RIVER VALLEY COMMUNITY SCHOOL**

**CONFIDENTIAL STUDENT HEALTH INFORMATION FORM**

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BIRTHDATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GRADE\_\_\_\_\_\_\_

ALLERGIES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY DOCTOR\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_FAMILY DENTIST\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TYPE OF HEALTH INSURANCE: Private \_\_\_\_\_Hawk-I\_\_\_\_\_Title 19/Medicaid\_\_\_\_\_No Insurance\_\_\_\_\_

IS YOUR CHILD COVERED BY ANY TYPE OF DENTAL INSURANCE? YES \_\_\_\_\_ NO \_\_\_\_\_

**HEALTH CONCERNS:** Mark the box if your child has a history of the following conditions.

□ Asthma or Reactive Airway Disease Triggers\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will an inhaler be needed at school? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_

Will the student carry their own inhaler? Yes \_\_\_\_\_  No \_\_\_\_\_

□ Diabetes Does the student use insulin? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_ Does the student have glucagon? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_

□ Seizure Disorder Does the student have rescue medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Allergies (Food, Insect, Seasonal, Medication) Yes \_\_\_\_\_\_\_ No \_\_\_\_\_

List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does the student have an EpiPen? \_\_\_\_\_\_\_

Will the student need a lunch accommodation? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_

Any Other Health concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Recent Surgeries or Hospitalizations? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_ If Yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Recent Serious Injuries or Accidents? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_ If Yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATIONS (Please list name, dose, time taken and reason for use)

**PERMISSION FOR ADMINISTRATION OF OVER THE COUNTER MEDICATION AT SCHOOL**

\_\_\_\_\_**I give permission** to the school to administer over-the-counter medications (such as but not limited to acetaminophen, ibuprofen, antibiotic ointment or cough drops) to my child if supply is available. Medication will be given per label indication and dosed according to age.

\_\_\_\_\_**I do not** want my child to receive medication at school.

**PERMISSION TO SHARE HEALTH INFORMATION**

At certain times it may be necessary and important to share your child’s health information with school staff and/or your healthcare providers. This is done strictly on a need-to-know basis only.

\_\_\_\_\_ **I give permission** to share Health Information with school staff and my doctor/dentist.

\_\_\_\_\_ **I do not** give permission to share my child’s health information.

Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_