

CONFIDENTIAL STUDENT HEALTH INFORMATION

EPPING MIDDLE SCHOOL

EVEN IF YOU DON'T ANTICIPATE THE ROUTINE USE OF OUR SERVICES ~

IN AN EMERGENCY THIS INFORMATION MAY BE VITAL IN HELPING US, and POSSIBLY EMT's BETTER CARE FOR YOUR CHILD!

PLEASE COMPLETE THE ENTIRE FORM ~ AS THOROUGHLY AS POSSIBLY ~ THANKS

PLEASE USE BLUE OR BLACK INK ONLY

DOB ___/___/___ Gender ___M___F Grade _____

Student's Legal Name _____ Nickname _____
Last First Middle

Local Primary Care Provider _____ Health Insurance ___YES___NO ___Not until ___/___/___
Town _____ Phone _____ Name of Company _____
Local Dentist _____ Local Orthodontist _____
Town _____ Phone _____ Town _____ Phone _____
Dental Insurance ___YES___NO Name of Company _____

HEALTH HISTORY [Please check all that apply ~ OR ~ specify NONE]

___ **Asthma [type & medication]** _____ Well-controlled ___YES___NO

___ **Diabetes [age of onset & medication]** _____ Well-controlled ___YES___NO

___ **Heart condition [type & medication]** _____ Limitations _____

___ **Environmental allergy [specify]** _____ Reaction _____ Treatment _____

___ **Drug Allergy [specify]** _____ Reaction _____ Treatment _____

___ **Food Allergy [specify]** _____ Reaction _____ Treatment _____

___ **ADD &/or ADHD [medication]** _____ Well-controlled ___YES___NO

___ **Seizure disorder [type & medication]** _____ Well-controlled ___YES___NO

___ **Bleeding issues [type & medication]** _____ Well-controlled ___YES___NO

___ **Surgery/ies [type]** _____ Date ___/___/___ Limitations _____

___ **Injury/ies [fractures, dislocations ~ specify]** _____ Date ___/___/___ Limitations _____

___ **Glasses &/or Contacts [Please circle one]** Distance ~ Reading ~ Everything

___ **Braces [Please circle one]** Teeth ~ Arm ~ Wrist ~ Leg ~ Ankle ~ Back ~ Neck **Reason for** _____

___ **Migraines [medication]** _____ Well-controlled ___YES___NO

___ **Concussion/s** Date ___/___/___ How occurred _____ **Side effects** _____

Loss of Consciousness YES/NO **Length of time** _____ Seconds _____ Minutes ~ **Seizure activity** YES/NO **Length of time** _____ Seconds _____ Minutes

___ **NONE** _____ **OTHER** _____

***Please include any other information that you would like to share with the Health Office, in order for your child to be ~ and stay ~ healthy and safe.
~ OVER, PLEASE ~*

Authorization and directions for EITHER prescription OR "over the counter" medications: ALL MEDICINE MUST BE IN

ORIGINAL CONTAINER WITH PRESCRIPTION LABEL CLEARLY VISABLE; MUST BE BROUGHT TO, AND DISPENCED BY, THE HEALTH OFFICE STAFF ~ PRESCRIPTION OR “OVER THE COUNTER” MEDICATION IS NOT PERMITTED IN STUDENT’S POSSESSION DURING THE SCHOOL DAY.

****Please note any prescription or “over the counter” medications your child takes at home, during non-school hours.**

Medication _____ Dosage _____ Route _____ Time _____
 Reason for giving _____ Possible side effects of medication **IN YOUR CHILD** _____

Medication _____ Dosage _____ Route _____ Time _____
 Reason for giving _____ Possible side effects of medication **IN YOUR CHILD** _____

Medication _____ Dosage _____ Route _____ Time _____
 Reason for giving _____ Possible side effects of medication **IN YOUR CHILD** _____

PERMISSION TO DISPENSE:

Acetaminophen [ex: Tylenol] ___YES ___NO Antacid tablets [ex: Tums] ___YES ___NO
 Ibuprofen [ex: Advil, Motrin] ___YES ___NO Antibiotic ointment ___YES ___NO

There are many products available to your child, in addition to those listed above. **Are there any “over the counter” products that you specifically do NOT want us to use for your child?** ___YES ___NO **Please specify** _____

Do you prefer to have this information shared **strictly** on a “need to know” basis? ___YES **With whom** _____
 Do you want **all** of your student's teachers to be given the above health information? ___YES ___NO

*****PARENT/GUARDIAN SIGNATURE** _____ **DATE** ___/___/___

We sincerely care about your student's health and safety. If you have any questions, comments or concerns, please feel free to call us in the Health Office, at EMS, 679-2544 ext 274/236 ~ 24 hour voice mail ~ or email us at the address/es below.

Lorraine Sawyer, RN, BSN, School Nurse
 Ext.274 ~ lsawyer@sau14.org

Suzanne Kukesh, ICCT, Health Assistant
 Ext.236 ~ skukesh@sau14.org

***** IF YOU WANT THIS INFORMATION KEPT CONFIDENTIAL [ON A “NEED TO KNOW BASIS”], PLEASE SEAL IT IN AN ENVELOPE WITH YOUR CHILD'S NAME AND “CONFIDENTIAL, FOR HEALTH OFFICE”. HOMEROOM TEACHERS WILL GET IT TO OUR OFFICE.**

~ **OR** ~ PLEASE FEEL FREE TO MAIL IT TO US: EMS @ 33 Prescott Rd., Epping, NH, 03042