# Ipswich Public Schools

## Annual Health Information Update
## School Year 2023-2024

**Student's Name: _____ Date of Birth: _____ Grade: _____**

**Home Address: _____**

**Parent/Guardian 1: _____ Relationship: _____**

**Primary Contact Number: _____Secondary Contact Number: _____**
**Please indicate cell ___work ___ home ___ cell ___ work ___ home ____**

**Parent/Guardian 2: _____ Relationship: _____**

**Primary Contact Number: _____Secondary Contact Number: _____**
**Please indicate cell ___ work ___ home ___ cell ___ work ___ home ____**

**Local person to contact in case parent/guardian cannot be reached: _____**

**Relationship: _____ Phone number: _____**

## Permission to Receive Over the Counter Medications

The School Nurse has my permission to administer the following medication: (check all that apply)

Note: Parents will receive a call prior to administering any oral medications to elementary students.

- ☐ Motrin (Ibuprofen, advil)
- ☐ Tylenol (acetaminophen)
- ☐ Cough Drops
- ☐ Tums
- ☐ Sunscreen (> SPF 30)
- ☐ Bug Repellent (< 30 DEET)

Parent Signature: _____ Date: _____

**Insurance Carrier: _____ Physician: _____**

**Additional Information/Comments:**_____

_____

**I HEREBY AUTHORIZE EMERGENCY TREATMENT FOR THE ABOVE NAMED STUDENT.**

**Parent Signature: _____ Date: _____**

☐ Doyon School ☐ Winthrop School

# Ipswich Public Schools

## Health History Form

**Child's Name: _____ DOB: _____ Age: _____ Grade: _____**

**Allergies:** Please list and describe any allergies (food, drug, and environmental):

| Allergy | Reaction (include trigger(s) for food allergies) | Treatment |
|---|---|---|
| | | |
| | | |
| | | |

**Food Restrictions:** (vegetarian, etc.)_____

**Health Conditions:** Check all that apply and describe

| | | | | | |
|---|---|---|---|---|---|
| ☐ | ADD/ADHD | | ☐ | Mental health condition | |
| ☐ | Asthma/respiratory conditions | ☐ inhaler | ☐ | Neurologic condition | |
| ☐ | Autism | | ☐ | Operation | |
| ☐ | Blood disorder | | ☐ | Scoliosis | |
| ☐ | Dental injuries, Braces | | ☐ | Seizure disorder | |
| ☐ | Diabetes | | ☐ | Skin condition | |
| ☐ | Ear infections/impairment | ☐ Hearing aid ☐ cochlear implant | ☐ | Speech condition | |
| ☐ | Frequent sore throats/strep | | ☐ | Substance abuse | |
| ☐ | GI conditions (crohn's, reflux) | | ☐ | Urinary condition | |
| ☐ | Headaches/migraines | | ☐ | Vision impairment | ☐ Glasses ☐ contacts |
| ☐ | Heart condition | | ☐ | Other | |
| ☐ | Hospitalization | | | | |

**Current Medications:** If your child requires specific medication during the school day, please contact your school nurse. Certain forms *must* be completed for medication to be dispensed during school hours.)

| | **Name(s)/ dose** |
|---|---|
| **Given at school:** | |
| **Taken at home:** | |

**Is there any condition that would prevent your child from participating in physical education or sports?**
If yes, please describe: _____

**Is your child followed by any specialty physicians/providers?**
If yes, please list**:** _____

**Please list any additional concerns or pertinent information:** _____
_____
_____

***I give permission for the School Nurse to share this information with my child's teacher(s) as needed for the benefit of my child's health and educational needs.*** **Yes** ☐ **No** ☐

Parent Signature: _____ Printed Name: _____

Date: _____