Ipswich Public Schools

Annual Health Information Update and Authorization for Emergency Treatment

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)

- ☐ Ibuprofen (advil, motrin)
- ☐ Tylenol (acetaminophen)
- ☐ Sudafed (Phenylephrine)
- ☐ Cough Syrup (Robtussin)
- ☐ Tums
- ☐ Cough Drops/Lozenges
- ☐ Midol (females only)
- ☐ NO meds to be given
- ☐ Other:

Consent for Medical Professional Collaboration

There may be occasions on which the school nurse may need to contact your physician or dentist for health information.

If you agree to this communication, please sign below.

I give permission for the school nurse to contact my child's provider(s) when necessary:

☐ **Yes** ☐ **No**

Insurance Carrier: _____ **Physician:** _____

Other Instructions/Comments: _____

_____

_____

I HEREBY AUTHORIZE EMERGENCY TREATMENT FOR THE ABOVE NAMED STUDENT.

_____ _____

(Signature of Parent/Guardian) **(Date)**

IF YOUR CONTACT INFORMATION **HAS CHANGED** FROM LAST YEAR, PLEASE INDICATE BY CHECKING BOX: ☐

☐ Paul F. 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: _____