

GRANBY PUBLIC SCHOOLS
YEARLY HEALTH INFORMATION FORM
(Replacing old Emergency Card)

Parent(s)/Guardian(s): to update your child's health information, kindly complete both sides of this form and return it to the school nurse by the end of the first week of school.

Student Last Name _____ First _____ MI _____ DOB _____

School Year _____ K-6 Teacher _____ Grade _____

Does your child have health insurance? No Husky Private (Name) _____

Name of Pediatrician/PCP _____ Phone: _____ Fax: _____

May the school nurse contact the pediatrician or PCP about health conditions listed on this form? Yes No

Section 1: Medications

1. Does your child take any medication at home? No, *proceed to next section.* Yes, *please list and use comment area on back of form for additional listings.*

Name: _____ Reason: _____

Name: _____ Reason: _____

Name: _____ Reason: _____

Name: _____ Reason: _____

Section 2: Allergies

1. Does your child have any allergies? No, *proceed to next section* Yes, *complete this section and check all that apply.*

Food (List food(s)) _____ Insect sting (list insect) _____

Medication (list medication(s)) _____ Animal(s) _____

Environmental (list) _____ Other: _____

2. Does your child have medication prescribed for allergies? No Yes, I will provide a completed Allergy Action Plan*

Section 3: Asthma

1. Does your child have Asthma? No, *proceed to the next section.* Yes, *please complete below.*

2. What are your child's usual triggers for their asthma? *Check all that apply.* Illness Exercise Cold/Heat

Environmental (ie: dust, pets, mold, pollen) List: _____

Other: _____

3. Does your child take daily asthma medication to control his/her asthma? No Yes, as listed in medication section above.

4. Will your child require asthma medication while at school? No Yes, I will provide a completed Asthma Action Plan*

5. Will your child use a preventative asthma medication before exercise? No Yes, I will provide a completed Medication Form*

Section 4: Other Conditions (*Check all that apply*)

Diabetes: Type I Type II ADD/ADHD Migraine Headaches Frequent Headaches (not migraines)

Seizures: Type: Grand-Mal (convulsions) Petite Mal (staring, unresponsive) Other _____

Frequent Stomachaches GI/GU Disorder _____

Emotional/psychological (ie: panic attacks, stress, bipolar, depression) _____

Scoliosis Muscular Skeletal Disorders: _____

Injuries within the last year (include dates) _____

Head Injury (ie: concussion) within the last year (include dates) _____

Surgeries within the last year (include dates) _____

Other: _____

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Section 5: Confidentiality

To provide the best learning environment and support for your child, and/or for the safety of your child while in school, it is sometimes necessary and helpful for the school nurse to inform your child's teachers, guidance counselors, administrator(s) and/or other professional school staff about your child's health issues. Please use the space below to indicate any information you would like to remain confidential with the nursing staff and would like not to be shared.

Section 6: Administration of medication by nurse and school personnel.

The school nurse has authorization by the school physician to administer the following selected over the counter medications to your child while in school. The administration of allowable medication is prescribed according to a written protocol for the nurses to follow. The purpose of these protocols is to allow the nurse to provide occasional relief of minor symptoms while your child is in school. The dosage will be determined by the age and/or the weight of the child according to the protocol and/or manufacturers recommendation. Should a child require more frequent or regular use of any of these medications, I understand that I will be contacted by the school nurse to obtain a medication order specific to my child. Parents/guardians may choose not to allow the nurse to administer one or all of these medications as allowed by protocol by checking NO after each medication not permitted.

- Acetaminophen (Tylenol) GRADES 1-12 ONLY (NO KINDERGARTEN)
Headache, fever, earache, minor aches and pains, menstrual cramps. NO Reason: _____
- Calagel, Caldryl or Calamine Lotion
Skin itching associated with minor rashes. NO Reason: _____
- Cough Drops/Throat Lozenges
Minor cough and sore throats NO Reason: _____
- Ibuprofen (Advil, Motrin) GRADES 7-12 ONLY
Headaches, fever, earache, minor aches and pains, menstrual cramps NO Reason: _____
- Oragel
Minor oral gum irritation NO Reason: _____
- Triple Antibiotic Topical Ointment or Neosporin Ointment
Minor cuts, abrasions or minor burns NO Reason: _____

Section 7: Comments and Authorization

Use this space to add additional comments, list additional medications or conditions.

I understand that it is my obligation to notify the school nurse of any changes to the information provided on this form; that it is my responsibility to provide to the school nurse any medication and appropriate written documentation by a physician for my child to carry and/or to have the school nurse administer any medication for which my child has been prescribed during the school day; that my child may be denied participation on field trips should I fail to provide proper authorization and medication for any serious condition for which my child has been prescribed an Epi Pen and/or Benadryl. This document and permission will need to be renewed annually at the start of every school year.

Printed Name of Parent/Guardian

Signature of Parent/Guardian

Date