Vermillion School District No. 13-1

Annual Health Record

School Year: _____ /_____

Student Name: _____ Birth Date: ___/___/___ M □ F □

School: _____ Grade: _____ Teacher: _____

1) Mother/Guardian Name: _____ Phone (H) _____

Mother/Guardian email: _____ Phone (C) _____

2) Father/Guardian Name: _____ Phone (H) _____

Father/Guardian email: _____ Phone (C) _____

3) Other Emergency Contact: _____ Phone _____

Physician's Name: _____ Phone _____

*** IT IS THE PARENT/GUARDIAN'S RESPONSIBILITY TO NOTIFY THE SCHOOL IF ANY CHANGES**

Medical History

* Please check the following. ****Additional paperwork is required for all bold entries**

□ **Severe/Life Threatening Allergies:** _____ **Epi Pen? Yes □ No □**

□ Food Allergies (please list)_____

□ Bee/Wasp Sting Allergy

□ Other Allergies:_____

□ **Asthma**	□ Blood Disorder
□ ADD/ADHD	□ Bone/Muscle/Joint Problems
□ **Cardiovascular (Heart) Disorder**	□ Celiac Disorder
□ **Diabetes**	□ Psych Disorder
□ Headaches/Migraines	□ Head Injury (Date: _____)
□ **Seizure Disorder**	□ Skin Disorder

□ Other (please explain) _____

_____

_

* Does your child take any Medications? **Yes** □ **No** □

Please list all medications your child is currently taking. **A Medication Authorization Form will need to be completed for any medications to be given at school.**

Medication	Time	Reason

* Does your child require special treatments, restrictions, or modifications related to their condition?

Yes □ **No** □ If yes, please explain:_____

_____

Vermillion School District No. 13-1

Medication Administration at School

***Please indicate that you read and understand by initialing on the line provided.**

_____ I acknowledge that all medications, including over-the-counter (OTC) medications and cough drops must have a signed medication authorization form signed by the parent/guardian.

_____K-12 Students are not permitted to carry and self-administer **prescription medications** while at school unless it is given to them by the school nurse or other trained personnel acting under the specific request of the parent or guardian. **Exceptions are made for asthma, anaphylaxis and diabetes – see Authorization for Self-Administration Form.** (HOMEOPATHIC SUBSTANCES AND NATURAL REMEDIES, HERBS AND VITAMINS ARE CONSIDERED PRESCRIPTION MEDICATIONS). A Consent for Medication form must be completed, signed and presented to the school by the student's parent/guardian.

_____ K-5 Students are not permitted to carry and self-administer any medications, including OTC medications. **Exceptions are made for asthma, anaphylaxis and diabetes – see Authorization for Self-Administration Form.** Medications may be administered by the nurse or authorized personnel with proper medication authorization forms. OTC medications must be in original containers. Prescription medications must be labeled from the pharmacy with proper instructions for use.

_____ Grade 6-12 Students may be authorized by a parent/guardian to carry and self-administer OTC/non-prescription medications. When such a request is made by a parent or guardian, an Authorization for Self Administration form must be completed, signed and presented to the school by the student's parent/guardian. (THIS DOES NOT INCLUDE HOMEOPATHIC SUBSTANCES AND COMPOUNDS, INCLUDING BUT NOT LIMITED TO NATURAL REMEDIES, HERBS AND VITAMINS).

This information will become part of your child's confidential permanent record. If for any reason you do not wish to respond to part(s) of this form you are under no obligation to do so. Please understand that we are not responsible for injury or illness that may be a result of these omissions.

By signing below, I understand that I am giving permission to share this information with school staff and trained personnel as needed with strict confidentiality maintained by all.

I understand that if the student identified herein uses any medication in a manner other than prescribed, the student may be subject to disciplinary action by the school, however, any disciplinary action may not limit or restrict the student's immediate access to the medication.

Parent/Guardian Signature: _____ Date: _____

Nurse Signature: _____ Date Reviewed: _____

□ Individual Health Care Plan
□ Medication Authorization Form
□ Special Diet Request
□ Other