

# HINSDALE

## SCHOOL DISTRICT

PO Box 27

Hinsdale, NH 03451

603-336-5332 HES or 603-336-5984 HMHS

FAX 603-336-7522 HES or 603-336-7497 HMHS

**This information is extremely important please make sure to answer every question. Thank you**

### SCHOOL INTERVAL HEALTH HISTORY

**EACH CHILD MUST HAVE THIS DOCUMENT ON FILE**

Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Health Insurance: \_\_\_\_\_ (Cigna, Aetna, NH State Health Plan, etc)

Would you like help enrolling your child in the NH State Health Plan? Yes \_\_\_ No \_\_\_

Dear Parent/Guardian:

**In order to keep your child's health record up to date, to provide the best possible health care while at school, we ask that you complete the following questions and return to the school nurse. If your child needs prescription medications at school, we must have a signed doctor's order and your signature. Medication must be brought in the original pharmacy labeled bottle.**

Date of last Physical: \_\_\_\_\_ Date of last Dental Exam: \_\_\_\_\_

1. What medicine if any does your child take? Name of drug \_\_\_\_\_ Dosage \_\_\_\_\_

Will it be taken at School YES \_\_\_ NO \_\_\_

For what condition? \_\_\_\_\_

2. Does your child have any other chronic health condition? \_\_\_ ADHD \_\_\_ ADD \_\_\_ Seizures  
\_\_\_ Diabetes \_\_\_ Heart Condition \_\_\_ Orthopedic Problems \_\_\_ Toileting Issues

\_\_\_ Behavior Problems \_\_\_ Spinal problems (scoliosis, Spina Bifida)

\_\_\_ Other health conditions not listed. Please explain  
\_\_\_\_\_

3. Please list any types of allergies (environment, food or medication)

\_\_\_ cats, dogs \_\_\_ other animal dander \_\_\_ grass \_\_\_ pollen \_\_\_ dust mites \_\_\_ trees

\_\_\_ PEANUTS/NUTS: Please explain reaction: \_\_\_\_\_

Does your child have an epi-pen? Yes \_\_\_ No \_\_\_ Does he/she know how to use it? Yes \_\_\_ No \_\_\_

\_\_\_ BEE ALLERGY: Please explain reaction: \_\_\_\_\_

\_\_\_ Food allergies Please list and explain what happens: \_\_\_\_\_

**THIS IS A TWO PAGE DOCUMENT PLEASE COMPLETE BOTH SIDES AND SIGN**

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**Please list medication allergies:** \_\_\_\_\_

4. Does your child suffer from frequent stomach or headaches? Please explain \_\_\_\_\_

5. Does your child have Asthma? Yes\_\_\_ No\_\_\_ What are the triggers? \_\_\_\_\_

What medications does he/she use? \_\_\_\_\_

Will there be an inhaler at school? Yes\_\_\_ No\_\_\_ Do you have one at home? Yes \_\_\_ No \_\_\_\_\_

6. Does your child wear glasses? Yes\_\_\_ No\_\_\_ For what reason? \_\_\_\_\_

Date of last eye exam \_\_\_\_\_

Were there any family losses or moves over the summer that may affect your child? Please explain below.

\_\_\_\_\_

Medications stocked in the nurse's office:

Acetaminophen (Tylenol)

Ibuprofen (Advil)

Antacid tablets

Benadryl or generic

Hydrocortisone cream

First aid cream

Bacitracin ointment

Anti-itch gel

Calamine lotion

Cough or throat drops: please send in, with a note, if your child needs them

I hereby request that my child be permitted to take the above over the counter medications if deemed appropriate by the school nurse or designee. The dosage shall not exceed the manufacturer's recommendations for age-appropriate dosage. This authorization shall expire at the end of the school year, or per parent request.

Known Allergies: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Print Parent Name: \_\_\_\_\_

### Release of Information

**I give permission for the school nurse at the Hinsdale School District to send and receive confidential medical information to and from my child's health care provider(s), to include immunization records, if necessary, after consulting with me.**

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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