Hinsdale School District
P. O. 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- No medication will be dispensed without a signed form for each child

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 ☐

I hereby give permission for the student (s) to be transported by ambulance in case of an emergency situation
Initials _____ Please Initial

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☐

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

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☐ BEE ALLERGY: Please explain reaction: _____

☐ Food allergies Please list and explain what happens: _____

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☐

   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)	First aid cream
Ibuprofen (Advil)	Bacitracin ointment
Antacid tablets	Anti-itch gel
Benadryl or generic	Calamine lotion
Hydrocortisone cream	

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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