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HINSDALE SCHOOL DISTRICT

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Karen Thompson, M.Ed.,
Director of Academics and Career Readiness

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School Interval Health History Form

EACH CHILD MUST HAVE THIS DOCUMENT ON FILE.
No medication will be dispensed without a signed form for each child.

Student's 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 give permission for my child to be transported by ambulance in case of emergency. _____ **Parent initials**

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.

1. Date of last Physical: _____ Date of last Dental Exam: _____

2. If your child is currently taking any medications, please complete the following:

Medication	Dosage	Taken at school?	For what condition?

3. Does your child have any chronic health conditions? ☐ ADHD ☐ ADD ☐ Seizures ☐ Diabetes

☐ Heart Condition ☐ Orthopedic Problems ☐ Toileting Issues ☐ Behavior Problems

☐ Spinal problems (scoliosis, Spina Bifida)

☐ Other health conditions not listed. Please explain: _____

_____

4. 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: _____

5. 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: _____

Please list medication allergies: _____

6. Does your child suffer from frequent stomach or headaches? Please explain _____

   _____

7. 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 ☐

8. Does your child wear glasses? Yes ☐ No ☐ Date of last eye exam: _____

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

   _____

The following are medications stocked in the nurse's office:

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

Note: Cough or throat drops are not stocked in the nurse's office. 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 my request.

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: _____