Newburyport Public Schools ***MUST BE COMPLETED AND SIGNED ANNUALLY***

PLEASE COMPLETE AND RETURN TO THE SCHOOL NURSE by September 6th

CONFIDENTIAL STUDENT HEALTH INFORMATION

STUDENT:

Last Name First Name Middle Name Date of Birth Grade

Primary Contact in the event of an emergency during school hours:

Contact #1 _____Phone # _____Contact #2 _____Phone # _____

Health/Medical Conditions: Check here if ❑ NONE or check all that apply:

Physical Developmental Conditions					
	Allergies		Contacts/Glasses/Visual		Cerebral Palsy
	❑ Bees ❑ Food ❑ Latex ❑ Medication ❑ Lactose ❑ Gluten List Specific Allergies/Intolerances: _____ Self Carries **Epi-pen**? ❑Yes ❑No_		Diabetes Type I Insulin by ❑ Pump or ❑ Injection		Spina Bifida
			Diabetes Type II		Seizure Disorder
			Dizziness/Fainting		Skin Rashes
	Celiac Disease		Ear Infection/Tubes		Neuromuscular Degenerative Disorder
	Constipation or Encopresis		Frequent Urination		Neurological Conditions: Other
	Blood Dyscrasias: ❑Hemophilia ❑Sickle Cell ❑Von Willibrand ❑ITP ❑Other Blood Dyscrasias		Hearing Deficit		Nose Bleeds
			Gynecological/Menstrual Issues		Asthma (current or history) or Breathing (Respiratory) Disorder If yes, used asthma medication within past two years? ❑ Yes ❑ No (Describe below) Self Carries **Inhaler**? ❑ Yes ❑ No
			Inflammatory Bowel Disease (IBS, Crohn's,etc)		
	Cancer: Type: _____		Kidney Disease		
	Cardiac Conditions		Lyme Disease ❑ Acute or ❑ Chronic		Pulmonary Hypertension
	Autoimmune Disorder (Arthritis, Lupus, etc.)		Migraine Headaches		Other Physical/Developmental Conditions
			Neurological Conditions:		Thyroid Problems
Behavioral/Emotional Conditions					
	ADHD/ADD		Depression		PTSD/Trauma History
	Anxiety (GAD, School Phobia, etc.)		Eating Disorders		Other Behavioral/Emotional Conditions
	Autism Spectrum Disorder		Difficulty communicating pain or discomfort		

Please provide additional details on health conditions that may require nursing services during the school day: _____

_____

_____

❑ **Uses adaptive equipment:** hearing aids, sound field amplifiers, wheel chair, or crutches **(**list**)** _____

❑ **Takes daily medication (list Name, Dose, Frequency):**_____

Is a student's parent or step parent enlisted in the military? ❒ No, not a member of a military family

❒ Yes, child of active duty member ❒ Yes, child of members or veterans who are medically discharged or retired for 1 year
❒ Yes, child of member who died on active duty

Health Provider Information

	Last Name	**First Name**	**Phone No**	**None**
Primary Doctor	_____	_____	_____	❑
Dentist	_____	_____	_____	❑

Health Insurance ❑ Yes ❑ No
Health Insurance Provider _____
Subscriber Name _____
Health Insurance # _____

Permissions:

My child has my permission to receive health/wellness and support services. I understand the information on this form will be shared with appropriate school personnel in order to meet my child's safety and health care needs. I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis and treatment.

In the event of a public health emergency, I give permission to the school nurse to administer **Potassium Iodide (KI)** (**see attached KI information sheet). Parent Signature: Yes** _____ **No** _____

I give permission to the school nurse to administer over the counter medications to my child per the **Newburyport Public Schools Medication Protocols** (see attached information sheet). To **refuse** one or more of the medications in this protocol, **please list here**:

_____

_____ _____ ***MUST BE COMPLETED AND SIGNED ANNUALLY***

Parent/Guardian Signature **Date**