

Milton Town School District
HEALTH INFORMATION FORM
School Year 2009-2010

PLEASE COMPLETE AND RETURN TO HEALTH OFFICE BY SEPT. 18, 2009

CHILD'S NAME _____ Birth Date _____
SIBLINGS (name and DOB) _____

Please be sure emergency contact information is up to date with the office. We use the same information in the event that we have to contact a parent/guardian (or other contact person) when a student is ill or injured.
Send all updated immunizations and physical exam results to the Health Office.

CHILD'S DOCTOR _____ PHONE NUMBER _____
Date of last Physical Exam _____ (Needs to be within the last 2 years in order to play sports-)
CHILD'S DENTIST _____ PHONE NUMBER _____
Date of last Dental Exam _____

1. DO YOU HAVE HEALTH INSURANCE? Y or N
If No, would you like information on DR. DYNASAUR? Y or N
2. Does your child wear: glasses contacts hearing aids N/A
3. Does your child have any ALLERGIES? Y or N
If Yes, what are they? _____
4. Does your child have ASTHMA? Y or N
If Yes, does your child use an inhaler, and what type? _____
5. Does your child have **ANY physical or mental health problem (s)** Y or N
If Yes, what? _____
6. Is your child on any medication (including at home and inhalers)? Y or N
Name of medication and dose _____
Does the medication need to be administered at school? Y or N
7. What is the date of your child's last **Tetanus Shot** ? _____

If medication needs to be administered at school, the school nurse must have a school district "PRESCRIPTION MEDICATION ORDER AND PERMISSION FORM" filled out and signed by an Medical Doctor.

The following medications may be administered by the School Nurse **if it is determined to be medically necessary.**

Acetaminophen (Tylenol)	Ibuprofen (Advil, Motrin)	Ambesol/Oragel
Diphenhydramine (Benadryl)	Calacium Carbonate (Tums)	
Triple antibiotic Ointment (Neosporin)	Calamine/Caladryl	

PLEASE LIST BELOW THOSE MEDICAITONS YOU DO NOT WISH TO BE GIVEN

NO I do not want the following medications given at school: _____

Emergency Contact Person: _____

Phone number: _____

Emergency Contact Person: _____

Phone number: _____

Who May transport my Child home : _____

IN THE EVENT THAT YOUR CHILD HAS A SERIOUS ACCIDENT OR A SUDDEN SERIOUS ILLNESS, THE SCHOOL WILL USE JUDGEMENT IN DETERMINING IF YOUR CHILD SHOULD BE TRANSPORTED BY AMBULANCE TO THE HOSPITAL, WHILE MAKING EVERY EFFORT TO REACH THE PARENT/GUARDIAN. I ACKNOWLEDGE AND AGREE WITH THE INFORMATION PROVIDED ON THIS HEALTH INFORMATION FORM.

**

PARENT/GUARDIAN SIGNATURE

DATE

e-mail address (optional): _____
Sometimes it is faster for us to contact a parent/guardian who works on the computer via e-mail)