2019-2020

Missisquoi Valley Union Middle & High School

Student Health Form

(This form must be completed every year. Please notify the school if any information changes during the school year. Your child WILL NOT be permitted to ATTEND ANY FIELD TRIPS or off grounds activity until this form is completed and returned.)

Please Return to the School Health Office Current Date: _____

Student Name: _____ Grade: _____

Date of Birth: _____ Home Phone: _____

Mailing Address: _____

911 Address (if different): _____

Mother/Guardian: _____ Daytime Phone: _____

Father/Guardian: _____ Daytime Phone: _____

With whom does the child live? _____

Emergency Contacts - *(Please list three nearby relatives or friends who will assume care of your child in the event a parent cannot be reached)*

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Parent / Guardian Signature: _____ **Date:** _____

********** **MEDICAL INFORMATION** **********

Health Insurance (Please check all that apply) Dr. Dynasaur/Medicaid _____ Private _____ None _____

Physician's Name: _____ Date of Last Physical: _____

Dentist's Name: _____ Date of Last Checkup: _____

_____ My Child does not currently have a Physician / Dentist

Has a doctor, nurse or other health professional EVER said that your child has asthma? _____ -

If yes, does your child STILL have asthma? _____ If yes, please provide a copy of your child's Asthma Action Plan

Please complete BOTH sides of this form
Return completed form to the Health Office

Please list **ALL MEDICATION** including those given at home, herbals and over the counter medications: (include dosage, frequency and reason for medication). Additional signatures are required for any medication being administered at school during the school day.

Please list **ALL ALLERGIES**: My child carries an **Epipen? Yes / No**

Allergy: _____Type of reaction: _____

Allergy: _____Type of reaction: _____

Please list any and all **health problems**/concerns:

Parent / Guardian Signature: _____Date: _____

I give permission for the school to administer the following medications: Please note this office uses various topical medications, ointments and lotions. It this is a concern please contact the health office.

Yes / No	Tylenol (acetaminophen)	Yes / No	Eye drops (saline solution)
Yes / No	Advil (ibuprofen)	Yes / No	Diamode (anti-diarrheal)
Yes / No	Benadryl (antihistamine)		
Yes / No	Tums (antacid)		

Parent / Guardian Signature: _____Date: _____

********** MEDICAL PERMISSION **********

Please circle "yes" or "no" for each of the permissions listed below

Yes / No	The School has my permission to contact my child's doctor/dentist for any necessary information that pertains to school such as immunizations, dates of physicals, dental visits, medications, attendance, or to discuss acute/chronic illness.
Yes / No	I give permission for my child to see Dr. Chiappinelli at MVU. I understand that this is a medical clinic service provided by Northwestern Medical Center and I will be financial responsible for services provided.
Yes / No	In the event of serious illness/injury and I am unavailable, I authorize MVU personnel to seek emergency care, including transportation to the nearest hospital/emergency room. I hereby authorize the physician in such event to administer whatever emergency treatment is necessary at my expense.

Please complete BOTH sides of this form
Return completed form to the Health Office

Parent / Guardian Signature: _____Date: _____

Please complete BOTH sides of this form
Return completed form to the Health Office