RSU #10
Health Information Form
CONFIDENTIAL

Name:_____ **Grade:**_____ **Teacher:**_____
Date of Birth:_____ **Address:**_____ **Phone:**_____
Father:_____ **Mother:**_____
Who does the student reside with: ___Mom ___Dad ___Both ___Shared residency ___Guardian
Guardian:_____ **Phone**:_____
Child's physician:_____ **Phone:**_____

Check any <u>HEALTH CONCERN</u>, giving explanation and dates, if possible. Please notify your school nurse if you have any questions or concerns. Thank you.

___ADD/ADHD (please circle)
___Allergy: Bee Sting (check below)
Mild___Moderate___Severe___
___Allergy: Food (list below)
Mild___Moderate___Severe___
___Allergy: Medication (list below)
___Allergy: Unknown causes
___Asthma (check below)
Mild___Moderate___Severe___
___Birth defect/Chromosome disorder
___Blood disorder
___Cancer (note diagnosis below)
___Cerebral Palsy
___Color blindness
___Cystic Fibrosis
___Depression
___Diabetes
___Ear/hearing problem (please explain)
___Epilepsy/seizure history
___Eye/vision problem (please explain)
___Heart disease/Defect
___Hemophilia
___Hyperactive
___Juvenile Rheumatoid Arthritis
___Kidney disorder (explain below)
___Medication prescribed (explain below)
___Medication needed at school
(form must be filled out)
___Migraine headaches
___Muscular Dystrophy
___Physical activity limited (requires PCP note)
___Prone to headaches
___Prone to nosebleeds (check one)
Mild___Moderate___Severe___
___Rheumatic Fever history
___Scoliosis
___Other (please explain)
___**NO KNOWN HEALTH PROBLEMS**

Explain (use other side if needed): _____
_____
History of accidents/ injuries/surgery/hospital stays (include dates): _____
_____

PERMISSION FOR MEDICAL TREATMENT

In the event of an emergency requiring medical attention, I hereby grant my permission to a physician or other hospital personnel designated by the RSU #10 staff to provide treatment for my son/daughter _____. I expect every effort will be made to contact me in order to receive my specific authorization before any treatment or hospitalization is undertaken.

FLUORIDE PROGRAM Grades K-5

Permission to participate in the fluoride varnish program twice a year
___Yes ___No

My child's health information may_____ may not _____ be shared with staff.

Parent/Guardian Signature:_____ Date: _____