CONTOOCOOK VALLEY SCHOOL DISTRICT

Health Information Form

****DO NOT COMPLETE THIS FORM if you have already submitted this information in CareDox****

Please answer all questions on this form to the best of your knowledge. Your responses will be shared with school personnel only on an as needed basis.

NAME OF STUDENT: ______________________________ **YOG**__________ **TODAY'S DATE:** __________

Parents/guardians: ______________________ Home Phone: __________ **Work/Cell:** __________

Parents/guardians: ______________________ Home Phone: __________ **Work/Cell:** __________

Doctor: ______________ Phone: __________ Medical Insurance? □ Yes □ No Company Name: __________

Dentist: ______________ Phone: __________ Dental Insurance? □ Yes □ No Company Name: __________

Please list 2 local people (other than parents) designated to assume responsibility for your student's health care in an emergency or non-emergency situation:

Name: ______________ Relationship: __________ Home Phone: __________ Work/Cell Phone: __________

Name: ______________ Relationship: __________ Home Phone: __________ Work/Cell Phone: __________

Are there any current medical concerns (including but not limited to vision, hearing, disease/illness)? Are there any limitations to normal daily activities? □ Yes □ No If yes, please explain: ______________________________

____

Any past medical concerns? □ Yes □ No If yes, please explain: ______________________________

____

Any medications taken at school or home: □ Yes □ No If yes, list the dosage and frequency: __________

____

Any **DRUG** allergies? □ Yes □ No If yes, to what? ______________ What is the reaction? __________

What is the treatment? ______________________________

Any **FOOD** allergies? □ Yes □ No If yes, to what? ______________ What is the reaction? __________

What is the treatment? ______________________________

Any **ENVIRONMENTAL** allergies (for example, pollen, bee stings)? □ Yes □ No If yes, to what? __________

What is the reaction? ______________________ What is the treatment? ______________________

If emergency medical treatment is required, and the parents or legal guardians cannot be reached immediately, your signature provided below empowers the school authorities to exercise their own judgment in taking the necessary steps to initiate treatment. I hereby authorize the ConVal School District staff or its agent to administer first aid and refer for medical treatment, including the option of releasing school medical records, ambulance transport, hospitalization or whatever may be reasonably required under the circumstances.

I hereby **give** □ **/do not give** □ permission for release/exchange of health information by telephone, mail or electronic exchange, including fax or email, between the school nurse, student's health care provider(s) and appropriate school personnel.

By signing below, I attest that all information is accurate and acknowledge that this is a legal document for use by Contoocook Valley School District.

______________________ ______________________________

(Date) **(Signature)**

____

(Relationship to student)