Your School Letter Head Here

ANNUAL HEALTH UPDATE & EMERGENCY AUTHORIZATION FORM

PURPOSE: To enable parents/caregivers to AUTHORIZE emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached. Upon completion, parents/ caregivers must return this form to the school. The original form and any copies thereof may be used to identify the medical options of the undersigned parent. The original form stays with the school nurse.

Stamford School District (School District) | Stamford Elementary School (School Building) | _____ (Home Room Teacher) | _____ (Grade)

Student's Full Name

_____

Last **First** **Middle initial**

Doctor's Name:	Phone
What was the date of your child's last comprehensive annual well care visit* received in their medical home? Date:_____	
Dentist's Name:	Phone
What was the date of your child's last dental exam received in their dental home? Date:_____	

*** A comprehensive well-care (physical) visit is not a sick appointment**

STUDENT'S MEDICAL HISTORY:

- **ALLERGIES: Serious- Requires epinephrine: (please describe)** _____

_____

- **ASTHMA:** Has a doctor, nurse, or other health professional EVER said that your child has asthma?
  _____ Yes _____ No _____ Don't know/not sure
  - If yes, does your child STILL have asthma?
    _____ Yes _____ No _____ Don't know/not sure
- **DIABETES? Yes ____ NO _____**
- **SEIZURES? Yes ____ NO _____**
- **MEDICATIONS taken on a regular basis (Please explain):**

_____

- **USE CORRECTIVE LENSES? YES_____ NO _____ HEARING AIDS? YES _____ NO _____**

Does your child have health insurance? Yes ____ No ____ If No, **dial 1- 855-899-9600** for Vermont Health Connect info [https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action]

IN CASE OF AN EMERGENCY INVOLVING MY CHILD, WHEN I CAN NOT BE REACHED: I hereby give consent to transport my child for medical care and authorize the providers and hospital to give any reasonable and customary medical and health care deemed necessary at my expense. It is understood that I will be financially responsible for all emergency care.

Signature of Parent/Guardian _____ **Date** _____

I give my permission for the school nurse or ***Tooth Tutor*** *(if available) to communicate with my dental provider:* ☐ Yes ☐ No

I give permission to exchange health information between my child's primary care provider and the school nurse, including vision and hearing screening information: ☐ Yes ☐ No

Signature of Parent/Guardian _____ **Date** _____

(Pg. 1 of 2) **OPTION FOR SCHOOLS: Complete Form on Other Side**

----------THIS SAMPLE FORM HAS two SIDES THAT MAY BE USED AT YOUR SCHOOL ----------

Please indicate if student has had or is currently under treatment for any of the following conditions:

_____BLEEDING DISORDERS _____
_____EAR/HEARING PROBLEMS _____
_____HEART PROBLEMS
_____HIGH BLOOD PRESSURE
_____HOSPITALIZED FOR SERIOUS ILLNESS, SURGERY OR ACCIDENTS? _____
_____

_____ MENTAL HEALTH CONDITION and treatment (Please explain):_____
_____
_____MUSCULAR WEAKNESS OR PARALYSIS
_____MIGRAINE HEADACHES
_____OTHER allergies: (Please list) _____
_____

_____PLEASE ADD ANY PROBLEMS NOT LISTED _____

Notes:

_____ _____ _____
Signature – Parent or Guardian Relationship to student Date