MSAD 49 New Student Health Form K-6

Student Name ____________________________________ **Date of Birth** ___________ **Grade:** ____ **School Year** _______________

Primary Healthcare Provider: ____________________________________**Dentist:** ______________________________________

Other specialists: ____

Yes	No		
		Accident (broken bone, head injury, major trauma etc) Please explain →	
		ALLERGIES: 1. **LIFE THREATENTING** (bees stings or other) Specify allergy: ___________________	My student will have an epi-pen at school: ☐ Yes ☐ No Describe previous reactions:
		2. Medication Allergy	
		3. Simple Allergy	
		Asthma	My student will be using an inhaler/nebulizer at school: ☐ Yes ☐ No Type of inhaler/nebulizer:
		Diabetes (circle one) Type 1 Type 2	Insulin Dependent? ☐ Yes ☐ No If yes, please see the school nurse to develop a diabetes care plan for your child.
		Hearing Problem	Repeated ear infections? ☐ Yes ☐ No Hearing aid: ☐ Yes ☐ No Tubes in ears? ☐ Right ☐ Left ☐ Both ☐ N/A
		Speech Problem	Currently receiving speech therapy? ☐ Yes ☐ No
		Vision Problem	Wears glasses: ☐ Yes ☐ No Wears contacts: ☐ Yes ☐ No
		Heart Condition	List condition: Any restrictions? ☐ Yes ☐ No If yes, please describe:
		Concussion (diagnosed by healthcare provider)	How many concussions? __________ Date of most recent concussion (M/YYYY): ______________
		Seizures	Describe seizures: Date of last seizure: __________ How frequent are seizures? ____________ My child requires emergency seizure medication at school: ☐ Yes ☐ No
		Emotional Issues (i.e anxiety, depression, PTSD, sleep issues) Please specify →	
		ADHD/ADD	On medication? ☐ Yes ☐ No
		Past surgeries? Please specify →	
		Other health conditions/issues?	

Parent/Guardian: Please complete both sides of this form.

Student Name: ____ Date of Birth: _________________ Grade: _________

Please list all current medications/supplements your child takes and the reason he/she is taking each medication: _____________
____
____

1. Will your student need to take daily or as needed prescription or over-the-counter medication at school? ☐ Yes ☐ No
   - If yes, a separate medication permission form needs to be filled out and signed by a parent/guardian AND prescribing health care provider. The medication permission form can be found on your school's website or the school nurse or school secretary can provide one for you upon request.

2. Were there any problems with the pregnancy and/or delivery of your child?

3. Does anyone smoke in your home/car?

4. Does your child have any toileting issues?

5. Are there any significant issues (family, emotional or psychological) that we should know about to better meet the needs of your child?

Name of parent completing this health update form (please print): _______________________________________ Date: __________

MSAD 49 Consent for Exchange of Healthcare Information

To be completed for students in ALL grades

Student Name: ____ Date of Birth: _____________________

I DO DO NOT (circle one) give permission for the exchange of information between my child's healthcare provider(s) and the school nurse at MSAD 49. I further understand my consent is voluntary and may be revoked (taken back) at any time in writing. This consent for exchange of information is effective for the current school year indicated: ______________________
(Current School Year)

Parent/Guardian Signature: ____ Date: ______________________

Parent/Guardian: Please complete both sides of this form.