Lamoille Union Middle School
2017/2018 Important Health Information

Please complete all questions and mail or fax to: Lamoille Union Middle School, Attn: Darcey Fletcher, 736 VT 15 W, Hyde Park, VT 05655 - (FAX # 851-1397). Student health forms must be completed and sent into the school every year.

Student Name: _____Date of Birth_____ Grade: _____

Student's Physician: _____ Date of last exam: _____

Student's Dentist: _____ Date of last exam: _____

Does your child have health insurance? Yes ___ No ____
Do you want information on health insurance? Yes ___ No ____
Does your child have dental insurance? Yes ___ No ____

I hereby give my permission for my student to receive the following medications at school:

Ibuprofen (Advil) ____ Acetaminophen (Tylenol) _____ Antacid _____ Benadryl (for allergic reactions) _____

Did your child receive any new immunizations over the summer? No ___Yes ___

If so, what was it? _____and what was the date given_____.

Has your child had the chicken pox? Yes____ No_____ If so, please provide the month/year _____

Is your child new to the school? ____ If so, attach immunization records or Fax to 888-2997.

My doctor's office may share immunization information with the school nurse. Yes _____ No _____

Has a doctor or nurse or other health professional EVER said that your child has asthma? Yes ___No____

If yes, does your child STILL have asthma? Yes____ No____ Don't know/not sure_____

How is it treated? _____

****Please attach an Asthma Action Plan from your provider and prescription order for inhaler use at school.**

Has a doctor or nurse or other health professional EVER said that your child has an allergy? Yes ___No____

If yes, does your child STILL have an allergy? Yes____ No____ Don't know/not sure_____

If so, what is the allergy? _____

Does your child have an EPIPEN prescribed by a health professional? Yes ____ No _____

If not, how is their allergy treated? _____

Is your child currently being treated for any physical or emotional health condition (Please explain):

Does your child take any medication daily? Yes ___ No ___If so, please list each medication, the dose, and frequency:

*****Signature of parent/guardian: _____**