Immaculate Conception School
Confidential Health Form
2020-2021

Form should be filled out by the child's parent or legal guardian. Please complete BOTH sides and sign where indicated.
RETURN COMPLETED FORM TO THE SCHOOL NURSE on or before September 2, 2020

Child’s name: ________________________________ Date of Birth: _______________ Male _____ Female _____
Grade: ___________ Teacher: _________________ Child’s Race/Ethnicity: ________________________________
Address:____

Parents/Guardian Information

Guardian name: __________________________ Relationship:___________________ Email: ____________________
Tel #(Home): ___________________ Cell # ______________________ Work#______________________
Guardian name: __________________________ Relationship:____________________ Email: ___________________
Tel #(Home): ___________________ Cell # ______________________ Work #_____________________

Emergency Contacts: Name:__________________________ Relationship:_______________ Tel #________________
Name:__________________________ Relationship:_______________ Tel #________________

Health/Medical Conditions: Check here if ❑ NONE or check all that apply:

	Physical Developmental Conditions				
	Allergies		Contacts/Glasses/Visual		Cerebral Palsy
	❑ Bees ❑ Food ❑ Latex ❑ Medication ❑ Lactose ❑ Gluten List Specific Allergies/Intolerances: ______________________ Self Carries **Epi-pen**? ❑Yes ❑No		Diabetes Type I Insulin by ❑ Pump or ❑ Injection		Spina Bifida
			Diabetes Type II		Seizure Disorder
			Dizziness/Fainting		Skin Rashes
	Celiac Disease		Ear Infection/Tubes		Neuromuscular Degenerative Disorder
	Constipation or Encopresis		Frequent Urination		Neurological Conditions: Other
	Blood Dyscrasias: ❑Hemophilia ❑Sickle Cell ❑Von Willebrand ❑ITP ❑Other Blood Dyscrasias		Hearing Deficit		Nose Bleeds
			Gynecological/Menstrual Issues		Asthma (current or history) or Breathing (Respiratory) Disorder If yes, used asthma medication within past two years? ❑ Yes ❑ No (Describe below) Self Carries **Inhaler**? ❑ Yes ❑ No
			Inflammatory Bowel Disease (IBS, Crohn’s,etc)		
	Cancer: Type:		Kidney Disease		
	Cardiac Conditions		Lyme Disease ❑ Acute or ❑ Chronic		Pulmonary Hypertension
	Autoimmune Disorder (Arthritis, Lupus, etc.)		Migraine Headaches		Other Physical/Developmental Conditions
			Neurological Conditions:		Thyroid Problems
	Behavioral/Emotional Conditions				
	ADHD/ADD		Depression		PTSD/Trauma History
	Anxiety (GAD, School Phobia, etc.)		Eating Disorders		Other Behavioral/Emotional Conditions
	Autism Spectrum Disorder		Difficulty communicating pain or discomfort		

Please provide additional details on ALL health conditions checked above: ____________________________________
____
____

Allergies (medications, foods, environmental) specify symptoms/reaction:_______________________________________
____

Does your child take any prescription, over the counter or herbal medications on a regular basis? YES ____ NO ____

IF YES, Please list medication(s) - (Name, Dose, Frequency): ____
____

Does your child require use of an inhaler for Asthma during school? YES____ NO ____

Does your child have an Epi-pen? YES____ NO_____

If your child requires an inhaler, epinephrine (or any prescribed medication) to be kept or given during the school day please provide the medication, Medication Administration Form signed by BOTH the parent/legal guardian and prescriber and an MA Asthma Action Plan and/or Food Allergy & Anaphylaxis Emergency Care Plan (as applicable)

All forms can be found on the school website or in the health office

Date of child's last physical exam:___________________ Date of last dental exam: ________________

Please provide a copy of most recent physical exam and immunizations

Medical Provider Information

Primary Care Provider Name:____ Phone # ___________________________

Dentist Name:____ Phone # ___________________________

Other Provider Name:____ Phone # ___________________________

Medical Insurance: ______________________________________Subscriber Name:______________________________

Policy #_________________________Group #_______________

Permissions - Please initial in spaces below.

______My child has permission to receive health/wellness, support services and emergency care per protocols outlined by the Immaculate Conception school physician. These protocols may include the emergency use of epinephrine and/or the AED (Automated External Defibrillator). ______I give permission for the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. I additionally give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis and treatment.

The school nurse has my permission to administer the following over-the-counter medications in accordance with the doctor's standing orders for Immaculate Conception School, prescribed by our school physician, Guy Navarra, MD.

Please check all that apply.

- ❏ Acetaminophen (Tylenol)
- ❏ Aloe Vera Gel
- ❏ Bacitracin
- ❏ Benadryl
- ❏ Calamine Lotion
- ❏ Calcium Carbonate (Antacid - Tums, Pepto)
- ❏ Hand Sanitizer (Alcohol-Based)
- ❏ Hydrocortisone 1% Ointment
- ❏ Ibuprofen (Advil, Motrin)

Parent/Guardian Signature: ____Date:________________

In the event of a public health emergency, I give permission to the school nurse to administer **Potassium Iodide (KI).**
See attached Potassium Iodide information sheet.

Parent/Guardian Signature: YES _______________________________ NO: ____________________________________

School Nurse Signature: ____Date:___________________

If you have any questions or concerns please contact the school nurse
Phone # 978-465-7780 Email: nurse@icsnewburyport.com