Immaculate Conception School
Confidential Health Form
2021-2022

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 August 1,2021

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 #_____0

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