*School Administrative Unit # 63*

192 Forest Rd Lyndeborough, NH 03082
603-732-9227

| Peter Weaver | Ned Pratt | Kristie LaPlante |
|---|---|---|
| Superintendent of Schools | Director of Student Support Services | Business Administrator |


# STUDENT HEALTH ASSESSMENT RECORD

**Check which school student will attend**

***GRADES: PRE-K - KINDERGARTEN***
☐ ***LYNDEBOROUGH CENTRAL SCHOOL***
192 Forest Road
Lyndeborough, NH 03082
Phone: 603-732-9228
**FAX: 603-654-6884**

***GRADES: 1 – 5***
☐ ***FLORENCE RIDEOUT ELEMENTARY SCHOOL***
18 Tremont St
Wilton, NH 03086
Phone: 603-732-9229
**FAX: 603-654-3490**

***GRADES 6-12***
☐ ***WILTON-LYNDEBOROUGH COOPERATIVE MIDDLE SCHOOL/HIGH SCHOOL***
57 School Rd
Wilton, NH 03086
Phone: 603-732-9230
**FAX: 603-654-2104**

Student Name:

_____ _____ _____
*Last Name* *First Name* *Middle*

_____ _____ ☐ Male ☐ Female School Year: _____
*DOB* Current Grade

Primary Care Provider: _____ Phone: _____

Specialist?: _____ Phone: _____

Family Dentist: _____ Phone: _____

Does your child have dental and health insurance? ☐ YES ☐ NO

If no, would you like information about finding coverage? ☐ YES ☐ NO

**Please check all that apply to your student**

☐ **Asthma** ☐ **EpiPen Prescribed** ☐ **Fainting/Blacking Out** ☐ **Wears Glasses/Contacts**

☐ **Cardiac Condition** ☐ **Seizures** ☐ **Frequent Strep Throat** ☐ **Wears Hearing Aids**

☐ **Diabetes** ☐ **Chronic Nose Bleeds** ☐ **Past Concussion(s)**

☐ **Allergy to:** _____

_____

☐ **Daily medication taken at home?** ☐ **YES** ☐ **NO**
**If YES, please list name, dosage, and frequency**

_____

_____

☐ **(!)Prescription medication needed during the school day?** ☐ **YES** ☐ **NO**
**If YES, please list name, dosage, frequency AND contact your school's nurse asap.** _____

_____

_____

**If your child has a different health issue not listed above, please provide any needed information here:**

_____

_____

**MEDICATION CANNOT BE ADMINISTERED, USED, OR CARRIED BY THE STUDENT WITHOUT WRITTEN CONSENT FROM BOTH THE PARENT/GUARDIAN AND A HEALTH CARE PROVIDER.**

Student Name:

_____ _____ _____

*Last Name* *First Name* D/O/B

**OVER-THE-COUNTER (OTC) MEDICATIONS:** All medications given by the school nurse require written consent from a parent/guardian. Below are the OTC medications available in the Health Office. ***Please do not add medications to the list, if a medication is not listed, it is not stocked.***

Please check each medication that your child may receive.

**I give permission for my child to receive the following over-the-counter medications at school:**

- ☐ **Advil** (*Ibuprofen)*
- ☐ **Bacitracin (***Antibiotic ointment***)**
- ☐ **Benadryl (***Diphenhydramine***)**
- ☐ **Burn Gel**
- ☐ **Caladryl Lotion**
- ☐ **Cough Drops/Throat Lozenge**
- ☐ **Insect Sting Swab**
- ☐ **Lip Balm/Vaseline**
- ☐ **Tums**
- ☐ **Tylenol** (*Acetaminophen*)

***(Note: The OTC Medications listed above may not be available at each school).***

## CONSENTS: Please read and initial each statement and then sign the form

I give consent for the above indicated medications to be given as instructed on the label. To the best of my knowledge, my child has no allergy to the selected medications. I agree to hold harmless SAU63 School District for any side effects which may occur as a result of taking the above indicated medications.

***INITIALS:*** _____

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I give my child's primary care provider and/or specialist permission to share information with the school nurse including but not limited to diagnosis, treatment plan, and medication administration. .

***INITIALS:*** _____

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I give the nurse permission to inform SAU63 employees in direct contact with my child of their health issues on a need to know basis if it impacts their safety.

***INITIALS:*** _____

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**For each service choose Yes or No:**

Basic school based health care services including care and treatment for illness and injury **YES** **NO**

**YES - response** Will authorize such treatments including, but not limited to, major or minor injury or illness, reported or observed while the student is at school. Failure to respond will result in an indication of "NO" for healthcare treatment.

**NO – response** Will result in calls to the parent/guardian for the student to be picked up for all medical concerns. This will be for all instances where students are feeling ill, present with bodily fluids, injuries such as cuts, scrapes, bumps, or bruises. EMS will be called for any situation deemed serious.

**Hearing Screening:** **YES** **NO**

**Vision Screening:** **YES** **NO**

When necessary, emergency health services such as first aid, CPR, or use of an AED will be performed until emergency medical services arrive. I understand that a fee may be involved with any ambulance transport.

I understand that this consent will remain in effect for the current school year, or until I indicate in writing that I wish to rescind this consent for health services.

**X** _____ _____

*Parent Signature* *Date*