2022-23

Missisquoi Valley Union Middle & High School

Student Health Form (This form must be completed every year. Please notify the school if any information changes during the school year. Your child WILL NOT be permitted to ATTEND ANY FIELD TRIPS or off grounds activity until this form is completed and returned.)

Please Return to the School Health Office Current Date: _____

Student Legal Name:	Grade:
Date of Birth:	
Mailing Address:	Home Phone:
911 Address (if different):	Cell Phone:
Mother/Guardian:	Daytime Phone:
Father/Guardian:	Daytime Phone:
With whom does the child live?	

Ethnicity/Race Please check all that apply:

☐ American Indian/Alaskan Native/Abenaki ☐ Asian ☐ Black/African American

☐ Hispanic/Latino ☐ Hawaiian/Pacific Islander ☐ White

Emergency Contacts - *(Please list three nearby relatives or friends who will assume care of your child in the event a parent cannot be reached)*

Name:	Relation:	Phone:
Name:	Relation:	Phone:
Name:	Relation:	Phone:

Parent/Guardian Signature:	**Date:**

********** MEDICAL INFORMATION **********

Please list **ALL MEDICATIONS** including those given at home, herbals and over the counter medications: (include dosage, frequency and **reason** for medication). Additional signatures are required for any medication being administered at school during the school day.

_____

_____

_____

Please list **ALL ALLERGIES**: My child carries an **Epipen? Yes / No**

Allergy: _____ Type of reaction: _____

Allergy: _____ Type of reaction: _____

Please complete BOTH sides of this form
Return completed form to the Health Office

Please list any and all **health problems**/concerns:

_____

_____

I give permission for the school to administer the following medications: Please note this office uses various topical medications, ointments and lotions. If this is a concern please contact the health office.

Tylenol (acetaminophen)	Yes	No	Tums (antacid)	Yes	No
Advil (ibuprofen)	Yes	No	Eye Drops (saline solution)	Yes	No
Benadryl (antihistamine)	Yes	No			

Parent/Guardian Signature:	**Date:**

Health Insurance (check all that apply) ☐ Dr. Dynasaur/Medicaid ☐ Private ☐ None

Physician's Name:	Date of Last Physical:
Dentist Name:	Date of Last Checkup:

☐ My child does not currently have a Physician / Dentist (circle all that apply)

Has your child ever had the chickenpox virus? ☐ Yes ☐ No

Has a doctor, nurse or other health professional EVER said that your child has asthma? ☐ Yes ☐ No ☐ Unsure/Don't Know

If yes, does your child STILL have asthma? ☐ Yes ☐ No

If yes, please provide a copy of your child's Asthma Action Plan for the 2022-2023 school year!

********** **MEDICAL PERMISSION** **********

Please circle "yes" or "no" for each of the permissions listed below

Yes / No — The school has my permission to contact and share information with my child's doctor/dentist. I also give permission for that doctor/dentist to share health information with the school, such as immunizations, dates of physicals, dental visits, medications, attendance and acute/chronic illness.

Yes / No — In the event of serious illness/injury and I am unavailable, I authorize MVU personnel to seek emergency care, including transportation to the nearest hospital/emergency room. I hereby authorize the physician in such an event to administer whatever emergency treatment is necessary at my expense.

Parent/Guardian Signature:	**Date:**

Please complete BOTH sides of this form
Return completed form to the Health Office