GILFORD SCHOOL DISTRICT HEALTH OFFICES

GILFORD ELEMENTARY	**GILFORD MIDDLE**	**GILFORD HIGH**
Jenn McGonagle RN	Beth Haddock RN	Meg Jenkins RN

Students Name ________________________________DOB _____Grade___________
Physician/PCP____________________________________ Tel_____________________

Please check if you need info regarding NH Healthy kids for insurance _________

Health Information

In an effort to protect your child's privacy, no information will be shared with teachers, and any appropriate staff members including bus drivers unless you agree to it in writing. Please review, sign and return the following information to the School Nurse.

Allergies _____ Asthma _____ Attention Problems_____ Bee Sting Reactor _____ Diabetes______ Frequent Nosebleeds _____ Headaches ______
Medication Allergies _______________ Rash/ hives ___ Seizures _____ Mobility Problems _____ Frequent stomach aches ______ Migraines _____
Glasses/contacts ____ Hearing _____ Mononucleosis __ other ___________________________________

History of sudden cardiac death in immediate family member? ______ History of fainting during exercise? _____ Fainting due to unexplained causes? ____
Any head injury? Concussion? ____________ Knocked out? _____________ Date(s) _____ _____ ______
Were you treated by a medical professional? ___________ Dates______ _______ ________
Have you had one or more serious sprain or strain of a joint? Knee_________ Ankle________ other______ Date(s) ________ ________

Comments____

►Parent /Guardian Signature_______________________________ Date _______

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Medication

*Students shall not carry any medication on them. Exceptions are a prescribed **inhaler** for asthma, an **Epi-pen** for severe allergic reactions and **insulin** for diabetes.*

- If your child has either of the above prescribed, contact School Nurse so you may get the correct form for the physician and you to fill out.
- If your child needs a **medication while at school**, please see School Nurse for the appropriate form. **Only medication that is in its original container will be accepted when dropped off by a parent or other adult.**

Please indicate which over the counter medication your child may have in the course of the day. If there is something not listed here and you wish it to be available for your child, please bring it to the School Nurse in an original container.

Please circle Yes or No:

Acetaminophen yes/no	**Antacids (Tums)** yes/no	**Chloraseptic** yes/no	**Bug Spray** yes/no	**Sunscreen** yes/no
Ibuprofen (Advil) yes/no	**Midol** yes/no	**Decongestant** yes/no	**Gum Soother (Oragel)** yes/no	**Diphenhydramine (Benadryl)** yes/no

►Parent/Guardian Signature ___________________________ Date ______

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Emergency Treatment

I understand that in case of illness or injury I will be notified as soon as possible and I give my permission for emergency treatment or surgery as recommended by physician.

►Parent/Guardian Signature ________________________________ Date ______