

GILFORD SCHOOL DISTRICT HEALTH OFFICES

GILFORD ELEMENTARY

Jenn McGonagle RN

GILFORD MIDDLE

Beth Haddock RN

GILFORD HIGH

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 _____

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 Mylanta yes/no Chloraseptic yes/no Bug Spray yes/no Sunscreen yes/no Ibuprofen (Advil) yes/no Midol yes/no Diphenhydramine (Benadryl) yes/no Decongestant yes/no Gum Soother (Oragel) yes/no

Parent/Guardian Signature _____ Date _____

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 _____