2020-2021

Annual Health and Emergency Authorization Form

Twin Valley Middle High School

4299 VT Route 100, Whitingham, VT 05361Phone # 802-368-2880 Fax # 802-368-7382

Student's Name:	DOB:	Age:	Grade:

School and Student Health Information:

For the Health Office to understand your child's health needs, we require parents/guardians to submit a completed Health and Emergency Authorization Form annually. Additionally, we want to bring to your attention the following important health information:

- Please read and complete all sections thoroughly before returning. Please use **black or blue ink** and print clearly.
- Students who require prescription medication(s) during school hours must have a signed Prescription Medication Order Form signed by a parent/guardian and your child's healthcare provider before the medication can be administered. Please remember that the school nurse is required to review and approve the medication, as well as train unlicensed assistant personnel (UAP) before the UAP can administer the medication. Therefore, a parent/guardian may be asked to come to the school to administer doses until the UAP has been trained and approved to administer the medication. Please provide immediate notice to the school nurse of any new prescription medications or any changes in current medications. Please discuss with your child's healthcare provider the possibility of the prescription medication being administered at home, once or twice a day, when the condition permits (ex. antibiotics, eye drops).
- A parent/guardian or a designated adult is required to transport all medications directly to and from the school. The medications are to be delivered to the school nurse or unlicensed assistant personnel (UAP). Students are not allowed to carry/deliver medications to/from home on the bus, with the exception of emergency medications that have been approved by the healthcare provider to carry and self-administer, such as inhalers or epi-pens.
- Students who miss school or were dismissed from school due to vomiting, diarrhea, or a fever, with no specific diagnosis should remain at home until they have had no fever for 24 hours WITHOUT the use of fever/pain reducing medications. There must be a full 24 hours before returning. Please be prepared to pick up your child immediately upon notification of an ill child at school.
- **Please keep your child home for any COVID-19 symptom**: cough, fever (TVMHS defines a fever as 100.4°F or greater), shortness of breath, chills, fatigue, muscle pain or body aches, headache, sore throat, loss of taste or smell, congestion or runny nose, nausea, vomiting, or diarrhea. Students who have been in close contact with someone with COVID-19 in the last 14 days must not come to school and must be excluded from in-person school activities. Parents/guardians will be notified promptly if his/her child becomes ill while at school and will be asked to arrange immediate pick up. Please refer to the Vermont Department of Health/Agency of Education for the most recent guidance for COVID-19 as information continues to evolve and change rapidly. Please be aware that the information provided today regarding COVID-19 may change. Students with a fever and no specific diagnosis should remain at home until they are fever-free for 24 hours **without** the use of fever-reducing medications. Healthy students with allergy symptoms (no fever) that cause coughing and clear runny nose may stay if they have medically diagnosed allergies and follow treatment plans. Students with well-controlled asthma will not be excluded. (Vermont Department of Health/Agency of Education, 2020)
- Please contact the school nurse if your child is diagnosed with any contagious illness. If your child is taking antibiotics, they must have a full 24-hour course before returning to school.
- Please verify that your child is up to date with immunizations and/or the proper paperwork is on file. Students entering PK, K, and 7th grade often require immunizations. It is best to confirm with your child's healthcare provider and provide updated immunization records to the school nurse. Please contact your child's pediatrician to schedule and learn the importance of the vaccines, including flu vaccine.
- If you have questions or concerns, please do not hesitate to contact your school nurse.

Permission for Emergency Treatment and Exchange of Medical/Dental Information

IN CASE OF EMERGENCY INVOLVING MY CHILD, WHEN I CAN NOT BE REACHED: I hereby give consent to transport my child for medical care and authorize the providers and hospital to give any reasonable and customary medical and health care deemed necessary at my expense. It is understood that I will be financially responsible for all emergency care. I authorize the school to release a copy of this annual health and emergency authorization form to the emergency personnel.

Signature of Parent/Guardian_____ **Date** _____

I give permission for the school nurse or **802 Smiles** (tooth tutor) (if available) to communicate with my child's dental provider:

☐ **Yes** ☐ **No**

I give permission to **exchange health information** between my child's primary care provider and the school nurse and the school nurse's designee, including vision and hearing screening information:

☐ **Yes** ☐ **No**

Signature of Parent/Guardian_____ **Date**_____

Student Name: _____ DOB: _____ 2020-2021

Please note: Confidential information about your child's health may be shared only with other school staff that need to know to protect your child's safety. They are told to keep this health information private and not to share with anyone else. If there is health information you would like not to be shared, please contact the school nurse.

Emergency Contact Information

Parent/Legal Guardian #1:	**Home Phone:**	**Place of Employment:**
Email:	**Cell Phone:**	**Work Phone:**
Parent/Legal Guardian #2:	**Home Phone:**	**Place of Employment:**
Email:	**Cell Phone:**	**Work Phone:**

***IMPORTANT*-Please list 2 nearby relatives or neighbors who will assume temporary care of your child if you can not be reached; in case of emergency, early school closings, illness, and/or injury. It is expected that children be picked up promptly upon notification of an ill child.**

Emergency Contact #1:	**Relationship:**	**Phone:**
Emergency Contact #2:	**Relationship:**	**Phone:**

Health and Dental Providers and Last Well-Care Visit Update

Healthcare Provider's Name:	Phone:

What was the **date** of your child's **last comprehensive, annual, well-child visit** conducted by his/her primary care provider?
(A comprehensive, well-care visit is not an appointment for sickness, injury, or chronic health need)

Last Well-Child Visit Date: _____ **Next Scheduled Well-Child Visit Date:** _____

Dentist's Name:	Phone:

What was the **date** of your child's **last dental exam** conducted by his/her primary dental provider?

Last Dental Exam Date: _____ **Next Scheduled Dental Exam Date:** _____

Health Insurance Update

Does your child have health insurance? ☐ **Yes** ☐ **No**

If not, please dial **1-855-899-9600 for Vermont Health Connect** to find out how to insure your child's health. You may also visit https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action to find out more. For local services and resources, call **2-1-1** and/or visit https://www.vermont211.org/. Please do not hesitate to ask school nurse for assistance.

Would you like the school to send you information about health insurance? ☐ **Yes** ☐ **No**

Dental Insurance Update

Does your child have dental insurance? ☐ **Yes** ☐ **No**

Would you like the school to send you information about dental insurance? ☐ **Yes** ☐ **No**

Any specific concerns about the health and well-being of your child? (Circle all that apply and please describe)

Emotional or Behavioral health, Growth and Development, Physical health, Oral health, Nutrition, Other:
☐ **Yes** ☐ **No** Explain:

Would you like assistance with other non-healthcare related resources? (Circle all that apply)

Food, Housing or Rent, Utilities (heat, electricity, internet), Childcare, Transportation, Interpreter, or Other assistance:
☐ **Yes** ☐ **No** Indicate Here:

Student Name: _____ DOB: _____ 2020-2021

Student Medical History Update: Please indicate if your child has had or is currently being treated for any of the following conditions

	Yes	No	Date/Additional Details
Bleeding Disorders			
Heart Problems			
High Blood Pressure			
Hospitalization for Serious Illness, Surgery, or Accident			
Mental Health Condition and treatment (please explain): *(ex. depression, anxiety, fears, trauma)*			
Muscular Weakness or Paralysis			
Migraine Headaches			
ADHD/ADD			
Concussion/Head Injury (When?)			
Other			

Allergies: Does your child have serious allergies that require epinephrine as treatment? ☐ **Yes** ☐ **No**
*(If yes, please provide the school nurse with a current **Allergy Action Plan** from your child's primary care provider. The school nurse will then write a school-specific plan with parents/guardians).*

Asthma: Has a doctor, nurse, or other health professional **EVER** said that your child has asthma?
☐ **Yes** ☐ **No** ☐ **Don't know/not sure**

If yes, does your child **STILL** have asthma? ☐ **Yes** ☐ **No** ☐ **Don't know/not sure**

Will your child require the use of an **inhaler** during school? ☐ **Yes** ☐ **No**
*(If your child currently has asthma, please provide the school nurse with a current **Asthma Action Plan** from your child's primary care provider. The school nurse will then write a school-specific plan with parents/guardians. If an inhaler is required, please supply an inhaler to the school).*

Diabetes: Does your child have diabetes? ☐ **Yes** ☐ **No**
*(If yes, please provide the school nurse with a **Diabetes Management Plan** from your child's primary care provider. The school nurse will then write a school-specific plan with parents/guardians).*

Seizures: Does your child have seizures? ☐ **Yes** ☐ **No**
*(If yes, please provide the school nurse with information for best management and a **Seizure Plan** from your child's primary care provider. The school nurse will then write a school-specific plan with parents/guardians).*

Eyes: Does your child wear corrective lenses? ☐ **Yes** ☐ **No** ☐ Glasses ☐ Contact Lenses

If yes, are corrective lenses for: ☐ Near vision ☐ Distant vision ☐ All the time

Date of last eye exam: Eye Specialist: Phone:

Ears: Does your child wear hearing aids? ☐ **Yes** ☐ **No** ☐ Right ear ☐ Left ear ☐ Both

Does your child have ear tubes? ☐ **Yes** ☐ **No** Right ear ☐ Left ear ☐ Both

Date of last hearing exam: By Whom: Phone:

Dental: Does your child wear braces? ☐ **Yes** ☐ **No**

Orthodontist Name: Phone:

Immunizations: Is your child fully immunized according to state regulations? ☐ **Yes** ☐ **No**

If no, has your child started a catch-up schedule with his/her primary care provider? ☐ **Yes** ☐ **No**

Medication History Update

Is your child taking any **prescription medicines** including an inhaler? ☐ **Yes** ☐ **No**
(If yes, please list below)

Name of Medication	Dose	Frequency + Time	Reason

What over-the counter medicines (OTC) does your child take **regularly?**

☐ Vitamins ☐ Herbals (please list):

☐ Other medicines like Tylenol, Motrin (please list): ☐ **None,** my child does not take any OTC medicines regularly.

Student Name: _____ DOB: _____ 2020-2021

Allergies

Any known **Allergies** (medication/food/other)? **If Yes,** please list: ☐ Yes ☐ No

If Yes, please explain reaction and preferred treatment:

Permission for Over-The-Counter Medications (OTC):
For each of the medications listed below or generic equivalents, please check to indicate that you are giving permission for a school nurse or front office to administer the medication during school or during school sponsored activities, according to the instructions on the manufacturer's label.

Acetaminophen (Tylenol)	Do you give permission for your child to have acetaminophen? ☐ Yes ☐ No	If you grant permission for your child to receive acetaminophen, has your child had acetaminophen before? ☐ Yes ☐ No ☐ N/A	If your child has had acetaminophen before, did he/she tolerate without suffering any ill effects or adverse reactions? If no, explain: ☐ Yes ☐ No ☐ N/A
Ibuprofen (Motrin)	Do you give permission for your child to have ibuprofen? ☐ Yes ☐ No	If you grant permission for your child to receive ilbuprofen, has your child had ibuprofen before? ☐ Yes ☐ No ☐ N/A	If your child has had Ibuprofen before, did he/she tolerate without suffering any ill effects or adverse reactions? If no, explain: ☐ Yes ☐ No ☐ N/A
Diphenhydramine (Benadryl)	Do you give permission for your child to have diphenhydramine for allergic reaction only? ☐ Yes ☐ No	If you grant permission for your child to have diphenhydramine, for allergic reactions only, has your child had diphenhydramine before? ☐ Yes ☐ No ☐ N/A	If your child has had diphenhydramine before, did he/she tolerate without suffering ill effects or adverse reactions? If no, explain: ☐ Yes ☐ No ☐ N/A
Triple Antibiotic Ointment	Do you give permission for your child to have triple antibiotic ointment? ☐ Yes ☐ No	If you grant permission for your child to have triple antibiotic ointment applied, has your child had triple antibiotic ointment applied before? ☐ Yes ☐ No ☐ N/A	If your child has had triple antibiotic ointment applied before, did he/she tolerate without suffering ill effects or adverse reactions? If no, explain: ☐ Yes ☐ No ☐ N/A
Ophthalmic Eye Wash	Do you give permission for your child to be treated with ophthalmic eye wash? ☐ Yes ☐ No	If you grant permission for your child to have ophthalmic eye wash, has your child used ophthalmic eye wash before? ☐ Yes ☐ No ☐ N/A	If your child has had ophthalmic eye wash before, did he/she tolerate without suffering ill effects or adverse reactions? If no, explain: ☐ Yes ☐ No ☐ N/A
Petroleum Jelly White (Vaseline) minor skin irritations, chapped lips	Do you give permission for your child to have petroleum jelly applied? ☐ Yes ☐ No	If you grant permission for your child to have petroleum jelly applied, has your child had petroleum jelly applied before? ☐ Yes ☐ No ☐ N/A	If your child has had petroleum jelly applied before, did he/she tolerate without suffering ill effects or adverse reactions? If no, explain: ☐ Yes ☐ No ☐ N/A
Pramoxine HCL/ Zinc Acetate (Calamine Clear Lotion) skin protectant, relieves itching	Do you give permission for your child to have pramoxine/zinc acetate applied? ☐ Yes ☐ No	If you grant permission for your child to have pramoxine/zinc acetate applied, has your child had pramoxine/zinc acetate applied before? ☐ Yes ☐ No ☐ N/A	If your child has had Calamine pramoxine/zinc acetate applied before, did he/she tolerate without suffering ill effects or adverse reactions? If no, explain: ☐ Yes ☐ No ☐ N/A
Sunscreen	Do you give permission for your child to have sunscreen applied? ☐ Yes ☐ No	If you grant permission for your child to have sunscreen applied, has your child had sunscreen applied before? ☐ Yes ☐ No ☐ N/A	If your child has had sunscreen applied before, did he/she tolerate without suffering ill effects or adverse reactions? If no, explain: ☐Yes ☐ No ☐ N/A
Cramp Tab	Do you give permission for your child to have sunscreen applied? ☐ Yes ☐ No	If you grant permission for your child to have sunscreen applied, has your child had sunscreen applied before? ☐ Yes ☐ No ☐ N/A	If your child has had sunscreen applied before, did he/she tolerate without suffering ill effects or adverse reactions? If no, explain: ☐ Yes ☐ No ☐ N/A
Cough Drop	Do you give permission for your child to have sunscreen applied? ☐ Yes ☐ No	If you grant permission for your child to have sunscreen applied, has your child had sunscreen applied before? ☐ Yes ☐ No ☐ N/A	If your child has had sunscreen applied before, did he/she tolerate without suffering ill effects or adverse reactions? If no, explain: ☐ Yes ☐ No ☐ N/A

To my knowledge, my child is not allergic and has no medical condition for which the selected medication would not be advisable. My child has permission to receive the approved medications listed above at school according to the instructions on the manufacturer's label. I am giving permission for the school nurse or unlicensed assistant personnel (UAP) to administer the medication at school according to the instructions on the manufacturer's label.

Signature of Parent/Guardian_____ **Date** _____