PARISH HILL MIDDLE/HIGH SCHOOL
304 Parish Hill Road
Chaplin, CT 06235
Phone: (860) 455-9584 Fax: (860) 455-9081

2023-2024 STUDENT HEALTH INFORMATION FORM

Please complete the front and back of this form and return it to the health office prior to the first day of school.

If your child has a medical condition that you would like to bring to the attention of the school nurse, please call: (860) 786-6035.

STUDENT NAME: __________________________________ **BIRTHDATE:**_________________ **GRADE**: ___

Please put an "X" by any of the following conditions that apply to your child:

__ Allergies and/or Anaphylaxis ___ Seizure Disorder ___ Hearing Impairment

___ Asthma ___ Migraines/Headaches ___ Vision Impairment

___ Diabetes ___ Recent Surgery ___ OTHER

If marked "X", please explain: ____

If your child has any **allergies**, please list them here: ____

Medications: ***A medication authorization form, signed by both the physician and the parent/guardian, must accompany all medications.*** If your child is prescribed any emergency medications (such as Insulin, Epinephrine Auto-Injectors or rescue inhalers for asthma) we may need to store spare medication in the health room. These medications can be administered by the school nurse or authorized school personnel. No more than a 90-day supply may be kept in the health office for any medication. Any medication to be used in school must be brought in by the parent/guardian by the first day of school. Any medication not picked up by the last day of school will be destroyed by the school nurse.

Does your child use any medications, including: prescriptions, over-the-counter medications, herbal remedies and/or vitamins? Yes _____ No __

Medication(s): _____________________________ Dose: _____________ How often: ______________________

Do you authorize permission for your child to receive cough drops in school – after the school nurse completes an appropriate assessment? YES __ NO ___ (Students should not bring in cough drops)

May we administer Acetaminophen (Tylenol) and/or Ibuprofen (Advil/Motrin) according to current standing orders based on weight, if needed, for mild pain? Please mark "X" below: You may check both.

____ACETAMINOPHEN ____IBUPROFEN _____No, please *do not* administer Ibuprofen or Acetaminophen

Notify the school nurse if at any time in the future your child *should not* receive this medication(s).

Physicals: Per Connecticut General Statues, an immunization update and additional health assessments are required in the 7th grade and in the 10th grade. Please note that students participating in sports need an up to date physical on file with the health office.

A parent or guardian will be contacted by the school nurse for any potentially serious illness, accidents, or reoccurring medical concerns. I have completed the above portion and understand its content.

Parent/Guardian: ____________________________________ **Date:** _______________
(Signature)

Parent/Guardian (*Print*): _____________________________

CONTINUE ON NEXT PAGE

PARISH HILL MIDDLE/HIGH SCHOOL
304 Parish Hill Road
Chaplin, CT 06235
Phone: (860) 455-9584 Fax: (860) 455-9081

2023-2024 STUDENT HEALTH INFORMATION FORM

Health Insurance Information:

Does your child have health insurance? YES__ NO___ If yes, please complete the information below:

Name of Insured: ____

Insurance Company Name: ____________________Health Insurance Identification Number: _________

Mother/Guardian Contact Information:

Name ________________________________ Address _______________________________________

Telephone: *home*_____________*cellular*____________________*work/day phone* ____________ _

Email ______________________________

Father/Guardian Contact Information:

Name ________________________________ Address _______________________________________

Telephone: *home*_____________*cellular*___________________*work/day phone* _____________

Email _____________________ _________

List three (3) friends, neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached:

CONTACT #1
Name: ______________________Relationship to student: ____________Phone: ___________________

CONTACT #2
Name: ______________________Relationship to student: ____________Phone: ___________________

CONTACT #3
Name: ______________________Relationship to student: ____________Phone: ___________________

Local Physician's Name: ___________________________ **Contact Number**: ____________________

Address/Office: ______________________________________

In case of accident or serious illness, the school will contact a parent/guardian. If the school is unable to reach the parent(s)/guardian(s), I hereby authorize the school to call the above indicated physician and to follow his/her instructions. If it is impossible to reach this physician or in case of emergency, the school may make whatever arrangements seem necessary for the safety of my child.

Parent/Guardian: ________________________________ **Date:** ____________________
(Signature)

Parent/Guardian: ________________________________
(Print)

CONTINUE ON NEXT PAGE