MEDICAL FORM 1 MED-1

Four Rivers Charter Public School **Also Complete Reverse Side**

A. STUDENT HEALTH HISTORY 2017-18

(In Answering the Following Questions, Please Circle YES or NO)

Name of Student: _____Grade: _____ Date of Birth: _____

1. Has the student had a physical examination in the last year? (If YES, give date of exam and doctor's name)_____	YES	NO
2. Does your child have ANY allergies? If YES, please describe what happened. _____ _____	YES	NO
3. Is your child allergic to bee stings or nuts? (If Yes, fill out Emergency Health Care Plan)	YES	NO
4. Does your child have asthma? List any asthma medications _____	YES	NO
5. Does you child have Diabetes? ☐ Type I ☐ Type II	YES	NO
6. Is your child susceptible to frequent colds and throat infections?	YES	NO
7. Has your child had any ear trouble or problems with hearing? If YES, please describe. _____	YES	NO
8. Has your child had any eye trouble or problems with seeing? If YES, please describe. _____	YES	NO
9. Does your child wear glasses or contact lenses? Date of last exam_____	YES	NO
10. Does your child see a dentist and/or orthodontist? If YES, please state dentist's name and any special problems. _____	YES	NO
11. Has your child had a concussion? When _____	YES	NO
12. Does your daughter have any menstrual problems? If YES, please describe. _____	YES	NO
13. Does your child have a history of convulsions or seizures?	YES	NO
14. Does your child have a heart condition?	YES	NO
15. Has your child had any marked changes in weight recently?	YES	NO
16. Does your child frequently complain of abdominal pain (stomach ache)?	YES	NO
17. Does your child have frequent headaches, or history of migraines?	YES	NO
18. Is your child taking **ANY** medications, tablets, vitamins or herbal supplements? If yes, please list ALL: _____	YES	NO
19. Does your child have any present physical limitations that may require program modifications or restrictions?	YES	NO
20. I give my permission for the School Nurse to communicate with health care providers regarding pertinent medical information.	YES	NO
21. Any other conditions not listed above: _____	YES	NO

Signature of Parent / Guardian *Date*

B. HEALTH PROVIDER and INSURANCE 2017-18

TO BE COMPLETED BY PARENTS/GUARDIANS (2-SIDED)

_____ _____

Student Name (please print) *Parent Name (please print)*

Doctor's Name and Telephone # _____

Does the student have Health Insurance? Yes _____ No _____

Health Insurance Provider_____ Policy Number-_____

Other information that will help us in an emergency: _____

_____

- **Emergency Health Care Plan Form MED-4:** Complete the form if your child has any life-threatening allergies or potentially life-threatening health conditions.

- **Medication Order Form MED-3:** Complete this form if your child will be taking any medication during the school day. Note: ALL medications must be kept in the School Health Office and administered by the school nurse or

C. OVER-THE-COUNTER MEDICATION CONSENT 2017-18

This form addresses over-the-counter medications only. Per Massachusetts Department of Public Health regulation, over-the-counter medications are to be given to students by the School Nurse or her specific delegate only. In order to have clear communication and permission regarding your child's health at school, please complete and sign below. If your child requires liquid or chewable forms of medication, please supply.

This regulation does not apply to prescription or over-the-counter medications with an M.D. or N.P. order. Administration of prescription medications can be delegated to certain staff/faculty during school hours or on school-related trips. (Please see enclosed Medication Order Form for prescription medications).

I give permission for my child to receive:	**Please check one:**	
Ibuprofen (Advil) for headaches, fever, muscle or bone pain menstrual cramps.	_____YES	_____NO
Acetaminophen (Tylenol) for headaches or fever.	_____YES	_____NO
Benadryl for allergy symptoms not requiring Epi-pen or as part of. a bee-sting protocol	_____YES	_____NO
Chewable Antacid for indigestion or upset stomach.	_____YES	_____NO
Calamine/Calagel Lotion for local skin rash or irritation.	_____YES	_____NO
Antibiotic ointment for superficial wounds.	_____YES	_____NO

_____ _____

Signature of Parent/Guardian *Date*