Milton Town School District
HEALTH INFORMATION FORM
School Year 2019-2020

This form is available online. You can view it on the Health Office Section on the MTSD Website

CHILD’S NAME_________________________________DATE__________________
BIRTHDATE __________________  TEACHER _________________________GRADE_____

Medical Information:

1. Doctor: ____________________________________ Phone number_______________
   Date of last well child visit: ____________________

2. Dentist:________________________________  Phone number _______________
   Date of last dental visit: ___________________

Please circle yes or no for the following questions:

3. Does your child have health insurance?      YES      NO
4. Would you like information on health insurance sent to you? YES NO
5. Has a doctor or nurse ever said that your child has asthma? YES NO
6. If yes, does your child still have asthma? N/A YES NO
7. Does your child wear corrective lenses? YES NO
8. Does your child wear hearing aids? YES NO

Please fill in the following questions to the best of you knowledge:

9. Is your child being treated for any physical or emotional health conditions?
   Please explain and list any specialists who care for your child:
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

10. Please list any medications your child takes on a regular basis (including inhalers):
    __________________________________________________________________________
    __________________________________________________________________________

11. Will your child need to take a prescription medication at school? YES NO
    *****If prescription medication needs to be administered at school, the school nurse must have a school district
    “Prescription Medication Order and Permission Form” filled out and signed by the custodial parent/guardian and a Medical
    Doctor. This form is available from the nurse’s office************

12. Please list any known food or drug allergies:
    __________________________________________________________________________
    __________________________________________________________________________
    __________________________________________________________________________
Below is the list of medications that we carry and routinely give in the nursing office. Your signature on this document is given Milton School District Nurses permission to administer any of these medications if we deem it to be necessary. Please indicate in the space provided which medications you would NOT like your child to receive.

<table>
<thead>
<tr>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen (Tylenol)</td>
</tr>
<tr>
<td>Bug Spray with DEET</td>
</tr>
<tr>
<td>Calamine/Caladry</td>
</tr>
<tr>
<td>Biofreeze/Bengay</td>
</tr>
<tr>
<td>Hydrocortisone Cream</td>
</tr>
<tr>
<td>Ibuprofen (Advil, Motrin)</td>
</tr>
<tr>
<td>Calcium Carbonate (TUMS)</td>
</tr>
<tr>
<td>Midol or Generic Form</td>
</tr>
<tr>
<td>Vaseline/Bag Balm</td>
</tr>
<tr>
<td>Lotion- Fragrance Free</td>
</tr>
<tr>
<td>Diphenhydramine (Benadryl)</td>
</tr>
<tr>
<td>Triple Antibiotic Ointment (Neosporin)</td>
</tr>
<tr>
<td>Ambesol/Oragel</td>
</tr>
<tr>
<td>Excedrin Migraine</td>
</tr>
<tr>
<td>Pepto Bismol</td>
</tr>
<tr>
<td>Eye Solution</td>
</tr>
<tr>
<td>Cough Drops</td>
</tr>
<tr>
<td>Sunscreen</td>
</tr>
<tr>
<td>Bactine</td>
</tr>
</tbody>
</table>

Medication I WOULD NOT like my child to receive:

13. How would you like to be contacted if your student come’s to the nurse’s office for non emergent situations that do not require your student to be picked up from school but the school nurse deems it necessary to follow up (please circle one)  

- Email  
- Phone Call

******Please note that this information will be pulled from PowerSchool, please update as changes occur*******

14. DISCLOSURE OF STUDENT RECORDS AND INFORMATION

Please sign this if you agree to allow your child's school nurse to exchange information with your child's health care provider(s). Occasionally, we (or the health care provider) need clarification about a health/wellness question/condition.

I give my permission to allow Milton Town School District Nurses to allow the following individual(s)/organization(s) ____________________________________________  

(Insert Health Care Provider Name and/or Doctor’s Office )

to release health/medical information (HIPPA - Health Insurance Portability and Accountability Act) regarding my child ___________________________.

(Insert Child’s Name)

(If so requested, a copy of the records disclosed pursuant to the prior written consent shall be provided to the parent or eligible student.)

In case of accident or illness, I request that the school contact me. If the school is unable to reach me, I hereby authorize the school to seek emergency care, including transportation to the emergency room. I hereby authorize the physician in charge to administer whatever emergency treatment is necessary at my expense. I ACKNOWLEDGE AND AGREE WITH THE INFORMATION PROVIDED ON THIS HEALTH INFORMATION FORM.

Guardian Printed Name: __________________________________________________________

Guardian Signature__________________________________Date______________________