PLAINFIELD SCHOOL
STUDENT HEALTH INFORMATION AND RELEASE FORM

2023-2024

(*By law, a separate form must be completed for each student every year.)*

Student's Name_____ Teacher/Grade_____

Primary Care Practitioner: _____ Phone #_____

Dentist: _____ _____ Phone #_____

Parent/Guardian Emergency Contact Information

Parent/Guardian #1_____Emergency #_____

Parent/Guardian #2_____Emergency #_____

Does your child have health insurance? Y_____ N____
(If your child doesn't have health insurance, call Children's Medicaid at 1-877-464-2447).

Name of Insurance Carrier: _____

Glasses/Contacts/None (circle). Are glasses for Distance or Reading (circle)?

Health Concerns: Please describe ***ALL*** significant health problems, concerns, disabilities or activity limitations that the school should be aware of (seizures, diabetes, asthma, migraines/headaches, cardiac problems, recent operations, constipation etc.)

_____
_____
_____

Allergies (this includes medication, food, seasonal or environmental):_____
_____
_____

Medications: Please list ALL medications your student is currently taking at home and at school. Permission forms are required for any medications needing to be administered at school. Forms are available at the main office and health office.

_____
_____
_____

Immunizations: *All students must have their most current immunizations on file with the health office. Please provide the most up to date copy at the beginning of each school year.*

-Continued on Reverse Side-

Hearing/Vision/Health Screenings: My signature below indicates my consent for my child to be screened, during school hours, with any unusual results to be reported to parent/guardian.

Parent/Legal Guardian Signature: _____ Date: _____

Permission to Administer Over the Counter Medications

I give permission for _____ to receive the following over-the-counter medication, as directed on the bottle, by the school nurse or their designee, if necessary: (please check each medication the school may use.)

- ☐ Acetaminophen (Tylenol)
- ☐ Antacids (Tums) 1-2 chewable tabs
- ☐ Cough Drop - 1 lozenge
- ☐ Benadryl Cream/Hydrocortisone
- ☐ Bacitracin antibiotic ointment
- ☐ Benadryl (diphenhydramine) allergic reaction
- ☐ Ibuprofen (Advil)
- ☐ Oragel
- ☐ Sunscreen
- ☐ Insect Repellent
- ☐ Saline Eye Drops

Parent/Legal Guardian Signature: _____ Date: _____

OR….

_____ DO NOT ADMINISTER ANY OVER-THE-COUNTER MEDICATION TO MY CHILD

Parent/Legal Guardian Signature: _____ Date: _____

Release of Medical Information *(optional)*

I hereby grant permission to Dr. _____ to release and share with the school nurse any information, which they deem to be in the best interest of my child, _____ inclusive of immunization records, medication information, appointment dates, allergies or other health concerns. I also grant permission to the school nurse to release to Dr. _____ all the information listed above. In addition to any information which they determine to be in the best interest of my child. I acknowledge that I understand the purpose of this request and that authorization is hereby granted voluntarily. I further understand that I may change or revoke this authorization at any time in writing.

Printed name of student: _____

Parent/Legal Guardian Signature: _____ Date: _____

For all health-related questions or concerns, please contact Beth Clifton, RN, MSN at 603-469-3250, or email schoolnurse@plainfieldschool.org