Sanford School Department
Annual Health Record

Date:____________

Student's Legal Name: ____________________________

Student's Preferred Name: ______________________________

Birth date: ____/____/____ Gender:_________________

School: ____________________________ Grade:_____________

Teacher/Program/LC:____________________________________

Parent/Guardian: ____ Phone number: ________________________

Parent/Guardian: ____ Phone number: ________________________

Emergency Names: Person(s) authorized for student when ill or who can act in an emergency when parents are unavailable.

Name: ____ Phone Number: _______________________

Name: ____ Phone Number: _______________________

HEALTH CONCERNS: ▢ **NO HEALTH CONCERNS**

ALLERGIES

Does your child have any life threatening Allergies: Yes ▢ No ▢

Food ▢ : ___________ Medications ▢ :___________ Bee stings ▢ **:**___________________ Seasonal/ Other ▢ :_____________

Does your child's allergy require an Epi-pen? Yes ▢*** No ▢

SEIZURES

Has your child ever been diagnosed with a seizure disorder Yes ▢*** No ▢

ASTHMA

Has your child ever been diagnosed as having asthma that requires an emergency inhaler? Yes ▢*** No ▢

DIABETES

Has your child been diagnosed with diabetes? Yes ▢*** No ▢

*****If yes to any above diagnoses, a plan and supplies must be provided*****

ADHD/ADD

Has your child been diagnosed by a medical provider as having ADD/ADHD Anxiety or Depression? Yes ▢ No ▢

If yes please specify:____

Does your child have any of the following illnesses or conditions? If yes, please explain on the back of the form.

▢ ASD ▢ Bowel/Bladder ▢ Bleeding disorder

▢ Heart condition ▢ Vision Problems ▢ Hearing Problems

▢ Migraines ▢ other_____________ ▢ other_____________

Medications:

List **ALL** medications that the student takes every day or when needed. If additional room is needed please use the back of the form.

Medication Name	Dose	How Often/Time	Reason for taking

I give permission for the school to give my child the following checked off medications as needed

(frequency per standing orders on an age-based and weight-based dosages)

☐ Tylenol (acetaminophen)	☐ Tums	☐ Antibiotic ointment
☐ Motrin/Advil (ibuprofen)	☐ Cough Drops (HS & MS only)	☐ Hydrocortisone cream
☐ Benadryl	☐ Orajel	☐ Icy Hot (HS only)

AUTHORIZATION TO RELEASE HEALTH RECORDS

I HEREBY AUTHORIZE MY CHILD'S HEALTH CARE PROVIDER(S) AND PREVIOUS SCHOOL TO RELEASE MY CHILD'S MOST RECENT PHYSICAL, IMMUNIZATION AND OTHER PERTINENT HEALTH INFORMATION TO SANFORD SCHOOL FOR COMPLETION OF HEALTH RECORDS. THIS AUTHORIZATION IS VALID WHILE STUDENT IS ENROLLED IN THE SANFORD SCHOOL DEPARTMENT. I GIVE PERMISSION FOR MY CHILD TO BE TREATED AT SOUTHERN MAINE HEALTH CARE IN THE EVENT OF AN EMERGENCY. IT WILL BE MY RESPONSIBILITY TO HAVE HIM/HER TRANSFERRED TO ANOTHER FACILITY IF I CHOOSE.

Parent/Guardian Signature____