THETFORD ACADEMY SCHOOL HEALTH INFORMATION CARD 2022-2023
(PLEASE PRINT)

STUDENT _____ GRADE _____ BIRTH DATE _____

PARENT/GUARDIAN NAMES _____

BEST PHONE NUMBER (S) TO REACH A PARENT DURING THE DAY _____

NAME OF HEALTH INSURANCE CO. _____ MEDICAID: Yes _____No_____

DOCTOR'S NAME/PHONE _____

Date of last comprehensive annual well care visit: _____

I give my student's physician permission to share immunization information with the school nurse: Yes _____No_____

I give permision to TA Health Office to share medical information with my child's pediatrician and receive information from August 15-June 30 of each school year. This permission may be withdrawn at any time. Yes _____ No_____

Covid Vaccine? Yes _____ No_____ Dates: _____/_____/_____/_____

DENTIST'S NAME/PHONE: _____

Date of last exam: _____

I would like assistance from the school nurse finding a medical or dental provider and/or medical or dental insurance for my student/family:
Yes_____ No_____

Ronald McDonald Mobile Dental Van – Medicaid number needed for this service _____

Does your child have any health issues, illness or disability that the school should be aware of? (Please attach a separate sheet if needed):

_____

_____

Please explain how the condition should be managed at school:

_____

MEDICATIONS TAKEN ON A REGULAR BASIS (If more room is needed please attach sheet.):

MEDICATIONS	DOSE	FREQUENCY	PRESCRIBED FOR

ALLERGIES: (document need for Epi-Pen) _____

EMERGENCY CONTACT: If your child becomes ill or is injured during school and we cannot reach you at the numbers provided above, please list a relative or friend who is authorized to act for you.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

If there is other information you would like the school to know, please attach a separate sheet.

IN CASE OF AN EMERGENCY INVOLVING MY CHILD, WHEN I CANNOT BE REACHED: I hereby give consent for transport of my child for emergency medical care and authorize the providers and hospital to give any reasonable and customary medical care deemed necessary. It is understood that I will be financially responsible for all emergency care.

_____ Date _____

PARENT SIGNATURE FOR EMERGENCY

I hereby give permission for my student to receive Tylenol, ibuprofen, antihistamine, cough drops, and Tums at the appropriate dose upon request to the school nurse or her designee.

_____ Date _____

PARENT SIGNATURE FOR ABOVE OVER THE COUNTER MEDICATIONS