St. Michael's Country Day School

2024/2025
Annual Student Health History

REQUIRED INFORMATION. PRINT & COMPLETE IN FULL.
DO NOT EMAIL THIS FORM TO SCHOOL

Student's Name:_____ Date of birth_____Grade_____

Address_____

Parent Contact #1:_____

Name Relationship to student Best phone #

Parent Contact #2: _____

Name Relationship to student Best phone #

EmergencyContact:_____

Name Relationship to student Best phone #

Check current or past Health Conditions:

Asthma____ Heart Conditions____ Bone or Joint Problems____ Anxiety___ Seizures___ Headaches___ ADHD___ Depression___ Diabetes___ Scoliosis___ Physical disability___ TB___ Eczema___ Bleeding Disorder___ Nose bleeds___ Strep throat___ Hives___Chicken pox____(must be documented by physician) Pneumonia___ Lyme Disease___ Concussion____ Earaches/infections___ Broken bones, if yes, which bones and year_____

Operations_____

Please provide any additional information or condition/injury not mentioned above:

_____

_____

MEDICATIONS

Does your child currently take medication, including inhalers, at home? Yes___ No___

Please list medications and reason for taking:

_____

Is there any medication that needs to be taken at school? Yes___ No___ If yes, please contact the school nurse.

MEDICATIONS IN SCHOOL (Including any over-the-counter medications) must be administered by a nurse, in accordance with physician orders and signed parent/guardian consent. No lay person other than a student's parent/guardian may give medication in school. All medications must be kept in the nurse's office or designated Epi location for that building. Emergency medications such as Epi pens, inhalers, glucagon and insulin, are exceptions to this rule and may be student carried and self administered, if physician approved, ordered, and in the Action Plan. Laystaff are trained to assist with emergency medications in accordance with state regulations.

ALLERGIES

Please list any known allergies,severity of reaction, and required treatments (including bee/insect stings, medications, environmental irritants, foods, etc.):

_____

All severe allergic reactions requiring Epinephrine will need an Emergency Health Care Plan and medication at school, please contact RN.

DIET: Does your child have any non-allergy dietary restrictions? Please list _____

Do you object to your child being given food at school related to curriculum/cultural learning and/or celebrations: Yes_____ No_____

VISION: Does your child have any difficulty seeing?_____ Wears glasses_____ Wears contacts_____ Date of last eye exam_____

(continued on next page)

HEARING: Does your child have any difficulty hearing? _____ Tubes or hearing aides?_____ Date tubes placed_____

DENTAL: RI state law mandates that all elementary students be examined by a dentist at least once per year, or evaluated by the school dentist. Please provide the name of your child's dentist:_____ date of most recent dental exam_____

PEDIATRICIAN: Name_____ Phone_____ date of most recent exam_____

COVID VACCINE (please check): NO: ____ Yes, date of first dose:_____ date of second dose: _____ booster:_____

Parent/Guardian Signature_____ Date_____

School Nurse: (401) 849-5970 ext. 389 Revised 3/2023