Haverhill Public Schools

FAMILY RESOURCE CENTER
45 FOUNTAIN STREET, HAVERHILL MA 01830
EMAIL: REGISTRATION@HAVERHILL-PS.ORG
TEL: 978-420-1951 / FAX: 978-469-8730

INITIAL / ANNUAL UPDATE HEALTH FORM

☐ New Student ☐ Established Student

Name of Student: _____ Sex: _____ Date of Birth: _____
Name of Person filling out form: _____ Phone:_____
School: _____ Grade: _____

HEALTH/MEDICAL CONDITIONS: CHECK HERE IF ☐ **NONE** OR CHECK ALL THAT APPLY:

PHYSICAL DEVELOPMENTAL CONDITIONS					
	Allergies ☐Seasonal ☐Bees ☐Food ☐Latex ☐Medication ☐Lactose ☐Gluten List specific allergies/intolerances: _____ _____ _____		Dental Problems *Specify:* _____		*Hearing Deficit* Left Right ☐Hearing Aids
			Diabetes ☐Type I ☐Type II Insulin by ☐pump ☐injection		*Visual* ☐Glasses ☐Contacts ☐ Preferential Seating
					Seizure Disorder *Specify*: _____
			Nose Bleeds		
	Asthma (current or history) If yes, used asthma medication within past two years? ☐Yes ☐No (Describe) _____		Postural (back) Problems *Specify:* _____		Blood Disorder *Specify*: _____
			Heart Condition *Specify:* _____		Neurological Condition *Specify*: _____
	GI (Stomach/Intestinal) Problems *Specify:* _____		Migraine Headaches		Skin Condition: *Specify:*_____
			Gynecological/Menstrual Issues		
	Urination Concerns		Kidney Disease		Other Physical/Developmental Conditions: *Specify:* _____ _____ _____
	Constipation or Encopresis		Lyme Disease ☐Acute or ☐Chronic		
			Ear Infections/Tubes		
BEHAVIORAL/EMOTIONAL CONDITIONS					
	ADHD		Depression		Other Behavioral/Emotional Conditions: _____ _____ _____ _____
	Anxiety (GAD, School Phobia, etc.)		Eating Disorder		
	Autism Spectrum Disorder		PTSD/Trauma History		

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Will your child need to take medication at school? Ex: Epi-Pen, Albuterol inhaler? ❑ YES ❑ NO

Have you traveled outside of the U.S. in the past 12 months? ❑ YES ❑ NO

If yes, where and for how long? _____

Primary Care Doctor Name: _____ Phone #: _____

Primary Care Dentist Name: _____ Phone #: _____

Do you have Health Insurance: ❑YES ❑NO

Health Insurance Provider: _____

Subscriber Name: _____

Health Insurance #: _____

Do you need help obtaining health insurance for your family? ❑YES ❑NO

PERMISSIONS

I give the school nurse permission to administer the following over the counter medication in accordance with the established protocols.

Ibuprofen/Advil/Motrin ❑**Tylenol/Acetaminophen** ❑ **First Aid Topicals** ❑ **Benadryl**

Tums (Tums will be administered only to students age 11 or older).

I understand alcohol based hand sanitizer is being offered in school per CDC recommendation. I do NOT want my child to use school provided alcohol based hand sanitizer. Check here: ❑

In case of an emergency, the school nurse will attempt to contact the parent/guardian. In the event that we are unable to contact you, your child will be transported by ambulance to the nearest hospital accompanied by a responsible adult.

Under FERPA guidelines, the school nurse will share information relevant to my child's health condition(s) and medication with appropriate school personnel that is needed to meet my child's health and safety needs.

Signature: _____ Date: _____