Nashua-Plainfield Community School District Health Update - School Year 2024-2025

Student's name:_____ **Date of Birth:**_____ **Grade:**_____ **Gender:**_____

HEALTH CONCERNS Mark the box ☒if your child has a history of the following conditions. Mark additional information as needed. **Additional forms may need to be completed by your physician (marked with a *).**

☐ **Asthma or Reactive Airway Disease**
- Triggers: ☐ Exercise ☐ Colds/Allergies ☐ Animals ☐ Smoke ☐ Weather ☐ Food ☐ Dust/Air ☐ Other: _____
- Will the inhaler ever be needed at school? ☐ No ☐ Yes ; **Asthma Action Plan***
- Will the student carry their own inhaler: ☐ No ☐ Yes ; **Authorization to Carry/Self Administer Medication***

☐ **Diabetes** ☐ Type 1 ☐ Type 2
- Does the student use insulin? ☐ No ☐ Yes ; **Diabetes Medical Management Plan***
- Does the student have glucagon? ☐ No ☐ Yes ; ☐ At School Office ☐ Backpack ☐ Locker # _____

☐ **Seizure Disorder Action Plan***
- Does the student have rescue meds? ☐ No ☐ Yes ; ☐ At School Office ☐ Backpack ☐ Locker # _____

☐ **Allergies** (Food, Insect, Seasonal, Medication)
- Is the student at risk for anaphylaxis at school? ☐ No ☐ Yes ; **Allergy & Anaphylaxis Emergency Plan***
- Will the student need lunch accommodations? ☐ No ☐ Yes ; **Diet Modification Form***
- Does the student have an EpiPen? ☐ No ☐ Yes ; ☐ At School Office ☐ Backpack ☐ Locker # _____
- List the allergies below:
  - ☐ Food(s): ☐ Peanut ☐ Tree Nut ☐ Eggs ☐ Milk ☐ Fish/Shellfish ☐ Soybean ☐ Gluten ☐ Other: _____
  - ☐ Insect Stings ☐ Seasonal Allergies ☐ Medication(s): _____ ☐ Other: _____

☐ **Heart Conditions/Murmur/Disease/Surgery** _____

☐ **Activity Restrictions (ongoing)** ; **Doctor's note required for explanation*** : _____

☐ **ADD/ADHD** ☐ **Emotional and/or Behavioral Diagnosis:** ☐ **Anxiety** ☐ **Depression** ☐ Other: _____

☐ **Headaches/Migraines:** _____

☐ **Bowel/Bladder Concerns or Incontinence:** _____

☐ **Assistive Equipment :** ☐ Glasses/Contacts ☐ Hearing Aids ☐ Wheelchair ☐ Other: _____

☐ **History or Concussion/Head Injury:** _____

☐ Other medical history or current medical/developmental concerns that could affect your child's education (*use back if necessary*):

_____

_____

MEDICATIONS *List ALL medications taken regularly at home or at school. Please specify frequency and reason for use. Use back if necessary.*

Medication:	Dose:	Time(s) Taken:	Frequency:	School/Home	Reason for use:

I give permission to the school to administer the following marked ☒over-the-counter medications if supply is available. Medication will only be given per label indication and dosed according to age.

☐ Tums ☐ Cough Drops ☐ Tylenol
☐ Ibuprofen (Grades 6-12) ☐ Hydrocortisone Cream ☐ Antibiotic Ointment

☐ I authorize the school to conduct vision, speech, dental, and/or hearing screenings for my child.
☐ I authorize the school nurse or designated personnel to administer first aid as needed.

Child's Doctor: _____ Phone #: _____ Preferred Hospital: _____
Child's Dentist: _____ Phone #: _____ Orthodontist: _____

*I understand that any medication sent from home to be taken at school needs to be in the original labeled container and a **Medication Authorization Form*** must be completed in order for it to be given. I understand that students may not carry any medications. I give permission to the school to contact my child's doctor/dentist to confirm appointments and authorize medications/plans of care as necessary. If an emergency should arise, school personnel are authorized to take whatever actions deemed in their judgment for the health and safety of my child. I will not hold the school district financially responsible for the emergency care and/or transportation of my child. I understand that it is my responsibility to update any of the above information as needed. I understand that this information is confidential but may be shared with appropriate school personnel when necessary for the child's safety or education.*

Parent/Guardian Signature: _____ **Date:** _____