



EAGLE HILL GENERAL MEDICAL INFORMATION FORM

In order that the best educational experience may be provided, school personnel must understand your child's health needs. This form requests information from you which will be helpful in our assessment.

Child's Name: _____ DOB _____

Address: _____

Parent/Guardian's Name: _____

Pediatrician's Name: _____ Phone Number _____

Address: _____

Date of Last Physical Examination: _____

I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in school:

Parent/Guardian Signature: _____ Date: _____

Allergies

1. Does your child have any medication allergies?

_____ Yes
_____ No

If yes, list each medication and reaction:

2. Does your child have any food allergies?

_____ Yes
_____ No

If yes, list each food and reaction:

3. Does your child have any environmental allergies (i.e. insects, pollen)?

_____ Yes
_____ No

If yes, list each with reaction:

(additional spaces on next page)

Medications

1. Does your child take daily medications?

_____ Yes

_____ No

If yes, list name of medication and reason for taking:

2. Does your child use medications occasionally? (including asthma inhalers)

_____ Yes

_____ No

If yes, list name of medication and reason for taking:

Activity

1. Does your child have any medical condition (current diagnosis, previous injury/condition) which limits his/her activity?

_____ Yes

_____ No

If yes, please explain:



From the Health Office Eagle Hill School

EMERGENCY MEDICAL INFORMATION FORM

Student's Name: _____ Date of Birth: _____

Father's Name: _____ Mother's Name: _____

Address: _____ Address: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

Family member or friend who can be reached when parents are not available:

_____ (name) _____ (phone) _____ (relationship to child)

Pediatrician's Name: _____ Phone Number: _____

Insurance Company: _____ Policy Number: _____

Emergency Information: List any and all conditions (i.e., sensitivity to insect bites, allergies, nightmares, etc.) that might be responsible for an emergency situation, and the treatment used:

Medications currently taken at home: _____

Consent to Administer: I give the school permission to administer the following medications during school hours as needed:

ADVIL _____ BENADRYL _____ ALEVE _____ TYLENOL _____

ADVIL COLD & SINUS _____ THROAT LOZENGES _____ ANTACID _____

Medical Release: In an emergency situation, every effort will be made to contact the parent or family physician. In the event that neither can be reached promptly, I hereby give Eagle Hill School the authority to obtain any medical treatment necessary for my child. I also give permission for the release of medical information for the confidential use of meeting my child's health and educational needs.

Parent/Guardian Signature: _____

Date: _____



PHYSICAL EXAMINATION FORM

NAME _____ **DATE OF BIRTH** _____

Height _____ **Weight** _____ **Blood Pressure** _____

Scoliosis/Spinal Deformity (Yes or No)? _____

Vision: **Right** _____ **Left** _____ **(No Glasses)**
 Right _____ **Left** _____ **(With Glasses)**

Hearing: **Right** _____ **Left** _____

TB Test: **Date** _____ **Reaction** _____

Last Tetanus shot (date): _____

Please answer the following questions based on your examination:

1. Is this student in good health and free of communicable diseases or physical/emotional conditions which might impede school performance? _____
2. Did you find this student to be physically qualified to participate in all supervised sports? _____
3. Does this student have a health condition which may require emergency action while at school? (Please specify condition and recommendations.) _____
4. Is this student on any long-term medication? (Please specify drug and diagnosis.) _____
5. Does this student have any allergies that the school should be aware of? _____
6. Can this student, with parental permission, take Advil, Tylenol, Sudafed or Benadryl at school? _____
7. Does the student have any special health needs which require modification of the school program? (Please specify needs and recommendations.) _____

This is to certify that a complete physical examination has been performed by me.

Name _____ **Date of Exam:** _____

Address _____

Physician's Signature: _____ **Phone Number:** _____



IMMUNIZATION FORM

*** Immunizations required prior to school enrollment as per the Connecticut State Law.**

DPT/DT At least 4 doses, with one of the doses after 4th birthday
 IPV/OPV 3 or more doses, with one of these doses after 4th birthday
 MEASLES One dose on or after the 1st birthday and second dose by age 12
 MUMPS One dose on or after 1st birthday
 RUBELLA One dose on or after 1st birthday
 VARICELLA One dose on or after the 1st birthday and second dose by age 12
 HEPATITIS B One dose of a series of three by age 12

NAME OF STUDENT: _____ DATE OF BIRTH: _____

IMMUNIZATION HISTORY

Vaccine Type	1 st Dose M/D/Y	2 nd Dose M/D/Y	3 rd Dose M/D/Y	4 th Dose M/D/Y	5 th Dose M/D/Y
DTP	*	*	*	*	
Td					
Polio (OPV or IPV)	*	*	*		
Measles / MMR	*	*		Booster for entry into K and 7 th grade (age 12)	
Mumps	*				
Rubella	*				
HIB Vaccine	*				Students under age 5
Hepatitis B Vaccine	*	*	*	Required for entry into K and 7 th grade (age 12)	
Varicella Vaccine	*			Students born 1/1/97 or later. Required for 7 th grade (age 12) entry.	

OTHER VACCINES (Specify)

Disease Hx As above:	_____ (specify)	_____ (date)	_____ (confirmed by)	
Chicken Pox:	_____ (specify)	_____ (date)	_____ (confirmed by)	

TB and Other Test Results (Sickle Cell, etc.)

TB: In high-risk group? _____ yes _____ no

Test	Date	Results

Physician's Name: _____ Phone Number: _____

Address: _____

Signature: _____ Date: _____



From the Health Office

Eagle Hill School

PHYSICIAN AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Name of Child _____ Date of Birth _____

Condition for which the drug is being administered _____

Drug _____

Dose _____

Method of Administration _____

Time of Administration _____

Medication shall be administered from _____ to _____

Relevant side effects to be observed, if any _____

If there are side effects, plan for management _____

Is this a controlled drug? _____

Physician's Name _____

Address _____

Physician's Signature _____ Date _____

PARENT AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

I hereby request that the medication ordered by the physician for my child be administered by school personnel. I understand that I must supply the school with the medication in the original pharmacy bottle or the original over-the-counter container. I understand that medication must be delivered to school by an adult and that any medication not picked up one week beyond the close of school will be destroyed.

Parent's Signature _____



PHYSICIAN AUTHORIZATION FOR THE ADMINISTRATION
OF OVER-THE-COUNTER MEDICATIONS

Name of Child: _____ Date of Birth: _____

Allergies: _____ Other Medications: _____

ADVIL 200mg ____
Dosage: 1 tab ____ 2 tabs ____
p.o. every 6 hours as needed

Reason: Headache, fever, muscle aches, menstrual cramps

TYLENOL 325 mg ____
Dosage: 1 tab ____ 2 tabs ____
p.o. every 4 hours as needed

Reason: Headache, fever

BENADRYL 25 mg ____
Dosage: 1 tab ____ 2 tabs ____
p.o. every 4 hours as needed

Reason: Allergy symptoms

THROAT LOZENGES
Dosage: 1 lozenge every ____ hour(s)

Reason: Sore throat, dry cough

ANTACID
Dosage: 1 tab ____ 2 tabs ____

Reason: Relief of heartburn or upset stomach

OTHER OTC MEDICATION:

Medication: _____ Reason: _____

Dosage: _____

Physician's Name: _____

Address: _____

Physician's Signature: _____ Date: _____

MEDICATION SHALL BE ADMINISTERED FROM SEPTEMBER – DECEMBER

PARENT AUTHORIZATION FOR ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL
I give the school permission to administer the above medications during school hours as needed.

Parent's Signature: _____ **Date:** _____