



**Health Office**  
 Lori Martin, RN  
 TEL. & FAX: (203) 302-3863  
 email: l.martin@eaglehill.org

**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 assessing your child's needs.

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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: \_\_\_\_\_

Please check correct answers to the following questions. Explanation of all "yes" answers should be given in the space provided below.

	<u>YES</u>	<u>NO</u>
1. Do you have any concerns about your child's general health (sleeping habits, weight, etc.)?	_____	_____
2. Has your child had any developmental problems (walking, talking, fine motor, etc.)?	_____	_____
3. Does your child have any allergies (food, insects, medications, etc.)?	_____	_____
4. Does your child have any problems with vision, hearing or speech (glasses, contact lenses, hearing aids, ear tubes)?	_____	_____
5. Has your child had any hospitalizations, operations or major illness? Specify problem.	_____	_____
6. Has your child had any significant injury or accident? Specify problem.	_____	_____
7. Does your child take any medications daily or occasionally (including asthma inhalers)?	_____	_____

Please explain "yes" answers from above and include age or year when appropriate.

---



---



---



---



# Health Office

Lori Martin, RN  
TEL. & FAX: (203) 302-3863  
email: l.martin@eaglehill.org

## 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. Condition and treatment:

\_\_\_\_\_  
\_\_\_\_\_

**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 in meeting my child's health and educational needs.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Health Office

Lori Martin, RN  
TEL. & FAX: (203) 302-3863  
email: l.martin@eaglehill.org

## 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 he/she is 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: \_\_\_\_\_



# Health Office

Lori Martin, RN

TEL. & FAX: (203) 302-3863

email: l.martin@eaglehill.org

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

DPT/DT	At least 4 doses, with one of the doses <u>after</u> 4 <sup>th</sup> birthday
IPV/OPV	3 or more doses, with one of these doses <u>after</u> 4 <sup>th</sup> birthday
MEASLES	One dose on or after the 1 <sup>st</sup> birthday and second dose by age 12
MUMPS	One dose on or after 1 <sup>st</sup> birthday
RUBELLA	One dose on or after 1 <sup>st</sup> birthday
VARICELLA	One dose on or after the 1 <sup>st</sup> 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 <sup>st</sup> Dose M/D/Y	2 <sup>nd</sup> Dose M/D/Y	3 <sup>rd</sup> Dose M/D/Y	4 <sup>th</sup> Dose M/D/Y	5 <sup>th</sup> Dose M/D/Y
DTP	*	*	*	*	
Td					
Polio (OPV or IPV)	*	*	*		
Measles/MMR	*	*		Booster for entry into K and 7 <sup>th</sup> grade -(age 12)	
Mumps	*				
Rubella	*				
HIB Vaccine	*				Students under age 5
Hepatitis B Vaccine	*	*	*	Required for entry into K and 7 <sup>th</sup> grade (age 12)	
Varicella Vaccine	*			Students born 1/1/97 or later. Required for 7 <sup>th</sup> 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: \_\_\_\_\_



# Health Office

Lori Martin, RN  
TEL. & FAX: (203) 302-3863  
email: l.martin@eaglehill.org

## 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 \_\_\_\_\_