2019-2020 White River Valley Schools Emergency Medical Form: Bethel or South Royalton Campus

Students Name: _____ **Date of Birth:**_____ **Grade:** _____

The following non-prescription medications are available from the school nurse/designee and can be given according to age, weight and manufacturer's instructions at nurse/designee discretion. Please **CROSS OUT if you DO NOT wish** your child to receive this medication.

Ibuprofen (Advil) Acetaminophen (Tylenol) Benadryl (For Allergic Reactions) Antibiotic Ointment Hydrocortisone/Benadryl Cream Antacid Skin lotion Aloe Sunscreen Vaseline (lip ointment) Eyewash/Eye drops Cough/Throat drops Orajel Wound Wash

I give permission for my child to receive the above medications (excluding medications which have been crossed out) from the school nurse or designee for the school year. In the case of minor injury or illness I consent for the school nurse/designee to treat my child. In an emergency, I hereby authorize school personnel to seek emergency Medical or Dental care, including the transportation via ambulance to the emergency room. The school will contact me or one of my designated contacts as soon as possible following initiation of emergency treatment. I further authorize that information can be obtained and disclosed between White River Unified District Schools and Emergency Departments, the doctor(s) and dentist(s) and specialist seen by my child for the purpose of continuity of care, sports physicals and immunization records for one calendar school.

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

Dentist's Name: _____ Dentist's Number: _____ Date of last Dental Exam/Cleaning: _____

Doctor's Name: _____ Doctor's Number: _____ Date of last Yearly Physical Exam: _____

Insurance Information: (Circle One)

Dr. Dinosaur/Medicaid MVP VHAP PCP VT BC/BS CIGNA None Other: _____

Group Number: _____ Policy Number: _____

If No, **dial 1-855-899-9600** for VT Health Connect :https://portal.healthconnect.vermont.gov/VTHBEL/and/welcome.action

Medical/Health Concerns (Example: Seizures, Diabetes, Mental Health Concerns):

_____

My child wears corrective lenses? YES_____ NO _____ Hearing aids? YES _____ NO _____

Asthma: Has a doctor, nurse, or other health professional EVER said that your child has asthma?

_____ Yes _____ No _____ Don't know/not sure

If yes, does your child STILL have asthma?

_____ Yes _____ No _____ Don't know/not sure ******If YES please send in Asthma Action Plan and bring in Inhaler.******

Allergies:

Allergy: _____ Symptoms:_____ Treatment (please circle) EpiPen Benadryl Other:____

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****If allergy requires an EpiPen please bring in a copy of Emergency Care Plan and EpiPen****

Daily Medications including prescription, over the counter and vitamins or supplements:

Name: _____ Strength: _____ Time of Day: _____ Reason:_____

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As per the school handbook, students are NOT permitted to carry any prescription or over the counter medications, except life saving medications (ex: inhaler, epipens, diabetic supplies/medications) with the proper permissions on file.

Health Hub: Students at our schools have access to medical care through the South Royalton Health Hub. This provides them the opportunity to see a Licensed Pediatric Medical Doctor. This Doctor can help with sick visits, sports physicals immunizations etc. This does not replace your primary care Doctor; but provides a service to help parents and students miss less work/class time. **I give permission for my child to be seen at the HealthHUB Clinic. I understand that I will be contacted prior to every appointment to give verbal permission and that my insurance will be charged per visit.**

Parent/Guardian Signature: _____ Date: _____