AUSABLE VALLEY CENTRAL SCHOOL
PRE-K HEALTH INFORMATION

Child's Name: _____ Age: _____ Birth date: _____

Address: _____ Phone Number: _____

Name of Family Physician or Provider:_____

_____

****All Pre-K students must have had a physical examination within the past year prior to attending the Pre-K program. Please provide copy of Doctor/Facility examination record.**

Health History during last 12 months:

Does this child have an ongoing health concern? (asthma, diabetes, etc.) ❑ Yes ❑ No
Does this child have any chronic illnesses or conditions? ❑ Yes ❑ No
Does this child have any allergies to medication, food or environmental? ❑ Yes ❑ No
Does the allergy require emergency treatment, such as EPI-PEN? ❑ Yes ❑ No
Does this child have problems with blood pressure, heart, or heart murmur? ❑ Yes ❑ No
Is there a history of any hospitalizations, significant injuries, or surgery? ❑ Yes ❑ No
Any dizziness, fainting, convulsions, seizures, or headaches? ❑ Yes ❑ No
Does this child have any problems with liver, spleen, kidneys, etc.? ❑ Yes ❑ No

Please describe medical concerns or allergies_____

_____

_____

Are there any CURRENT medical concerns/injuries? See below ❑ Yes ❑ No

❑ Head/concussion _____ ❑ Glasses/contacts_____ ❑ Eyes _____ ❑ Ears_____
❑ Hearing_____ ❑ Throat _____ ❑ Nose /Nose bleeds_____
❑ Chest _____ ❑ Respiratory _____ ❑ Cough_____ ❑ Neck_____
❑ Cardiovascular _____ ❑ Gastrointestinal _____ ❑ Heat exhaustion/stroke_____
❑ Genitourinary _____ ❑ Neurological _____ ❑ Skin disease _____
❑ Musculoskeletal (include any fractures, etc.) _____
❑ Hernia_____ ❑ Teeth _____ ❑ Dental appliances _____

Does this child take any medication regularly at home? ❑ Yes ❑ No
Name of Medication_____ Dosage_____ Frequency_____

Require medication at school? ❑ Yes ❑ No
Name of Medication_____ Dosage_____ Frequency_____

Is this child on any special diet or food restrictions? ❑ **Yes** ❑ **No**

Describe child's nutritional pattern and dietary intake: _____

_____

List any significant medical concerns or sudden death of family members:

❑ **Mother**_____ ❑ **Father** _____ ❑ **Grandparents** _____
❑ **Siblings** _____ ❑ **Other** _____

Please describe any YES responses:

_____

_____

The above information is current and correct to the best of my knowledge.

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

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HIPPA LAW

Due to recent changes in confidentiality laws, it is difficult to exchange needed information with Health Care Providers. For this reason, we would ask that you complete and sign the release below. Information requested may include, but not be limited to, immunization records, physical forms, medication authorization, and restriction or release or activity information. Your physician may also request that you sign a similar release.

I authorize the exchange of pertinent medical and/or psychological information between the physician and the school nurse for my children listed below:

_____ _____ _____

Student(s)

_____ _____

Parent/Guardian Signature **Date**

In Case of Emergency

I understand the final disposition of an emergency case, the judgement of the school authorities will prevail. Anytime this information must be changed, I will notify the nurse in writing.

Parent /Guardian Signature