BENSON VILLAGE SCHOOL
32 School Street
Benson, VT 05743

STUDENT HEALTH/EMERGENCY INFORMATION

Student's Name: ________________________________ DOB: ____________Grade: ___
Age: ____ Allergies: ________________________________ (medication, food, bees, latex)

Medical History	YES	NO	Details
Allergic reaction above listed allergen(s)			Anaphylaxis, difficulty breathing, hives, rash, vomiting, other **(please circle all that apply)** **Do they need an Epi-pen or Benadryl?**
Diabetes			
Asthma			**Date of Last Attack-** **Does student need inhaler at school? YES NO** **Do they need an inhaler before PE or recess? YES NO** **Do they need an inhaler on a field trip? YES NO** **Please list name of inhaler(s) below**
Asthma Action Plan in place by physician?			If so, please ask physician to fax this to us at 537-2494.
Seizure Disorder, if yes, what type:			Date or age of last Seizure: taking medication, please list below.
Heart Disease/Disorder			
High Blood Pressure			
Any Surgeries?			
Any Hospitalization History?			For:
ADHD or ADD (circle one)			If taking medication, please list below
Mental Health Diagnosis (Depression, Anxiety, PTSD, ODD OCD)			If taking medication, please list below
Migraines			If taking medication, please list below
Stomach or Digestive Disorders (Reflux, IBS)			Describe: List medications below
Vision Impairment			Glasses or Contacts (please circle)
Hearing Loss/Hearing Aid			One or both ears?
History of Concussion/Head Trauma (TBI)			Date:
Any other illness, injury or condition impacting school that is not listed above? Please Describe.			
Has he/she had the chickenpox			What month and Year?

Daily Medication List:

Name Dose Time of Day Taken

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____

STUDENT'S NAME:________________________DOB:___________GRADE:________

Primary Parents/Guardians:______________________________relationship:____________

Address:____

Home Phone:_____________Work Phone:_____________Cell Phone:________________

Secondary
Parent/Guardian(s):__________________________relationship______________

Address:____

Home Phone:___________Work Phone:______________Cell
Phone:___________________

Please list 2 relatives/friends who are **available during school hours** (in the event that we are unable to reach you) that can release your child from school for illness or injury or pick them up from school if need be:

1.______________________Relationship:______________Day Phone:______________

2.______________________Relationship:______________Day Phone:_____________

Child's Doctor:_____________________ **Date of last Physical:**___________

Child's Dentist:_____________________**Date of last Cleaning:**_____________

Specialist (if applicable)__________________________________

Has a doctor, nurse or other health professional EVER said that your child has asthma? YES NO

If yes, does your child STILL have asthma? YES NO

Does your child have Medical Insurance? YES NO Dental Insurance? YES NO

Would you like information on obtaining health insurance mailed to you YES NO

***Please check with the school nurse 537-2491 on the date of the last physical on file at the school if your child is participating in any athletic activities.**

In case of accident or illness, I request the school to contact me. If I can not be reached, I hereby authorize the school to seek medical care, including transportation to the Emergency facility. I hereby authorize the physician in charge to administer treatment as necessary at my expense.

Signature of
Parent/Guardian:______________________**Date:**_________________________