Hill View Montessori
Student Health Form

Student Name: _____

Date of Birth: _____ Grade: _____

Medical Treatment

In case of an emergency, HVM will make every effort to contact the parent/guardian. In the event we are unable to contact the parent/guardian, your child will be transported by ambulance to the nearest medical care facility and/or to _____ Hospital.

(*Please specify preferred hospital*)

Physician Name: _____ Phone Number: _____

Dentist Name: _____ Phone Number: _____

Please check all that apply to your child:

☐ Diabetes ☐ Asthma ☐ Seizure Disorder ☐ ADD/ADHD ☐ Other: _____

☐ Hospitalizations/Surgeries: _____

☐ Allergies (food, insects, medication, environment):

_____

_____

_____

My child currently receives the following medication(s) **AT HOME**:

Name:_____Dose:_____How Often:_____Why?/Diagnosis:_____

Name:_____Dose:_____How Often:_____Why?/Diagnosis:_____

Name:_____Dose:_____How Often:_____Why?/Diagnosis:_____

Name:_____Dose:_____How Often:_____Why?/Diagnosis:_____

If your child will need to have medication(s) administered **AT SCHOOL**, you must contact the School Nurse to have the proper plans in place, ONLY the school nurse may administer medication to your child.

Permission to Administer Over the Counter Medication

I give the School Nurse permission to administer the following over the counter medications in accordance with established protocols. (*Check all that apply*)

☐ Ibuprofen/Motrin, Advil ☐ Acetaminophen/Tylenol ☐ Tums ☐ Benadryl

HIPAA/FERPA Notice Information

I give permission to the School Nurse to share information relevant to my child's health condition and medication with appropriate HVM staff or contracted person coming in contact with my child, to meet my child's health and safety needs.

Parent/Guardian Signature: _____ Date: _____

(Expires at the end of the current school year)

Daytime Phone Number: _____

Reviewed August 2022