Horace W. Porter School Health Room
PO Box 166, Columbia, CT 06237
Phone (860) 228-9493
Fax (860) 228-8592

Initial Health Update

Name: _____ DOB: _____ Home Phone: _____

Address: _____

Grade: _____ Homeroom Teacher: _____

Medication Allergies: _____ Reaction Type: _____

Food Allergies/Sensitivities/Intolerances: _____ Reaction Type: _____

Bee Sting Allergies: _____ Reaction Type: _____

Seasonal Allergies: _____ Reaction Type: _____

Please list all the medication with dosages that your child takes at home or at school, or on an as needed basis including over the counter and herbal medications with dosages:

_____

_____

*If medication needs to be administered at school, please call the Health Room for forms.

Please list all the medical conditions/diagnoses that your child has:

_____

_____

***The nurses are required by Connecticut State Law to screen each child in grades 5-8 annually for scoliosis. Do you want your child to be screened? Yes___No____**

Has your child had any significant sports injuries or fractures? _____ If yes, please note nature of injury, date of injury, and treatment.

_____

_____

Please list any treatment/procedures your child will need to have done at school: (nebulizer, tube feeding, blood sugar monitoring, etc.)

_____

_____

Any other health concerns? _____

_____

_____

Physician's name and phone number: _____
Specialist's name and phone number: _____
Dentist name and phone number: _____

If you do not have insurance, are you interested in information about the HUSKY Program?
Yes _____ No_____

Do we have permission to administer Tylenol and Ibuprofen (Motrin, Advil) to your child per our standing orders?

Tylenol:	o Yes _____	o No _____
Ibuprofen:	o Yes _____	o No _____

My signature grants permission to the Health Office Staff or their designees to call the persons whose names I/we have listed as Emergency Contacts on the Emergency Contact Form if my child becomes ill at school and requires transportation, either to my home or to the Emergency Contact's home. The Emergency Contacts named are aware that the school has my/our permission to call during the school day. I/We agree to update this emergency information each school year. I/We agree to notify the school if any of the information on the Emergency Contact Form changes during the course of the school year.

My signature indicates a statement of intent and assurances:
In the event of any medical emergency or accident, or the possibility that a serious situation is developing, the Columbia School System reserves the right to call an ambulance and to move the ill or injured student to the nearest medical facility.

I/We give permission for the Health Office Staff to forward health information on "a need to know" basis, ex. alert staff for symptoms to watch for and give records to EMS in case of an emergency.

My signature indicates a statement of financial responsibility:

I/We agree not to hold the Columbia School System financially responsible for the emergency care and/or transportation of my/our child to the hospital or medical facility.

Parent/Guardian Signature:_____Date:_____