

FERRY BEACH ECOLOGY SCHOOL

8 Morris Avenue, Building One ~ Saco, Maine 04072 ~ (207) 283-9951 ~ www.fb.es.org

Student Health Form

Dear Parents/Guardians: Please provide to us below a *complete* record of your child's health history and current health status so that we can care for your child's health and safety in our residential school program setting. *If your child, due to health reasons, must self-carry an Epi-Pen or Inhaler please contact your child's classroom teacher for a release form to sign. We also require a duplicate Inhaler or Epi-Pen on site to be kept in the Nurse's office while your child is a student at FBES. If your child has a medical condition, additional health information may be required.* If need be, please contact your school nurse or the FBES on-site nurse to discuss your child's needs.

Please fill out this form completely including signatures. All information is confidential.

Student's Name _____

School Name _____ **Teacher's Name** _____

Gender: M ___ F ___ **Date of Birth** _____ **Height** _____ **Weight** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Parent/Guardian Names _____ **Home Phone(s)** _____

Father's Employer _____

Phone Number _____ **Cell Phone** _____

Mother's Employer _____

Phone Number _____ **Cell Phone** _____

Emergency Contact if above not available:

Name/Relation _____ **Contact Number(s)** _____

Student's Physician _____ **Phone Number** _____

Health Insurance Provider _____ **Policy Number** _____

Date of Student's last Tetanus Booster _____

Will your child take medication while at FBES? Yes ___ **No** ___

MEDICATIONS:

Please list all medications student will take at FBES. All medications must be sent with teachers. DO NOT PACK WITH STUDENT. MEDICATIONS MUST BE IN ORIGINAL CONTAINER CLEARLY LABELED BY PHARMACY WITH CORRECT DOSAGE AND TIME FOR ADMINISTRATION.

<u>Medication Name</u>	<u>Dose</u>	<u>Time(s)</u>	<u>Reason for taking</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please fill out page 2

Please list any known allergies and describe reaction that occurs:

Medications: _____

Food: _____

Bees/Insects: _____

Other: _____

Check all applicable health conditions of student and explain below:

- | | |
|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Recent orthopedic injury |
| <input type="checkbox"/> Bathroom issues | <input type="checkbox"/> Recent surgery |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> ADD or ADHD |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Diabetic |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Special Education |
| <input type="checkbox"/> Behavior issues | <input type="checkbox"/> Recent illness |
| <input type="checkbox"/> Psychiatric conditions | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Recent trauma in home/family | <input type="checkbox"/> Sleepwalking, bedwetting |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Does your child require aid in classroom? |
| <input type="checkbox"/> Ever been hospitalized? | <input type="checkbox"/> Religious beliefs associated with medical intervention |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> Heart condition | |
| <input type="checkbox"/> Nose bleeds | |

Please explain All items checked above:

Occasionally, it is necessary to administer non-prescription (over-the-counter) medication to students while at FBES (for headaches, sore throats, stomachaches, etc.). These medications can only be administered with parent/guardian permission.

Please sign here to give permission for your child to receive over-the-counter medications if needed at FBES.

Signature: _____

Date: _____

Treatment Permission

In the event of a medical emergency, I, _____ (print parent/guardian name), grant permission for FBES staff, Student's school staff, or an ambulance to transport my child and I grant permission for any doctor, clinic, or hospital to perform emergency treatment as deemed necessary for my child.

I further authorize FBES Nurse to administer medications listed above to my child as scheduled.

Signature: _____

Date: _____