Crossroads Academy Student Health Information Form

Please complete this form prior to the first day of school. Once completed, it can be emailed to healthoffice@crossroadsacademy.org.

Emergency contact information, and names of your physician and dentist should be updated annually in your Veracross Parent Portal *(https://portals.veracross.com/crossroadsacademy/parent)*

Student Name: _____ Current Grade: _____

Name of student's primary care provider/pediatrician: _____
Provider's Phone Number: _____

Date of student's last wellness exam: _____

For New Students
Please submit a copy of the official updated immunization record to our nursing staff prior to the first day of school at healthoffice@crossroadsacademy.org. The immunization name, month, day, and year should be listed.

For Returning Students
Please submit a record of any immunizations given within the last 12 months to the above email address.

For Incoming 7th Grade Students
Please submit a record of the student's Td or Tdap immunization to the above email address.

Crossroads Academy complies with the State of New Hampshire Department of Health and Human Services required school immunizations. We do recognize religious or medical exemptions.

Please list any medical conditions the student has been diagnosed with such as diabetes, epilepsy, asthma, ADHD, significant illnesses or injuries:

_____
_____
_____
_____

We understand that students will be having medical appointments throughout the school year so please update us either in the Health/Medical section on Veracross or by emailing us at

healthoffice@crossroadsacademy.org of any new diagnoses, allergies, medications, or other pertinent health information.

1. Are there any health problems that would require school modifications for your child's participation in physical education, field trips, or other school activities?

   Yes ____ No _____

   If yes, please explain: _____

   _____

2. My student's primary care provider/pediatrician has determined that he/she is able to participate in the full school program as described in the program description, including physical education:

   Yes ____ No _____

3. Does the student have any allergies, including medications, food, and insect stings?

   Yes ____ No _____

4. Does your child use any emergency medications for their allergies, such as an Epi pen?

   Yes ____ No _____

If yes, please have the student's primary care provider/pediatrician complete the Crossroads Academy Prescription Medication Form' OR include the prescriber's signed order form. This is required to be updated every 12 months.

5. **List Student's Current Medication(s):**
   - **a.** _____
   - **b.** _____
   - **c.** _____

If a prescription medication is needed during school hours, please have the student's primary health care provider/pediatrician complete the 'Crossroads Academy Prescription Medication Form' OR include the prescriber's signed order form. This is required to be updated every 12 months.

6. **Does your child require emergency oral medications, such as glucagon or seizure medications?**
   Yes ____ No _____

If yes, please have the student's primary health care provider/pediatrician complete the **Crossroads Academy Prescription Medication Form** *OR include the prescriber's signed order form.*
This is required to be updated every 12 months.

7. **Does the student use an inhaler? Yes ____ No _____**

   If yes, please indicate the medication name: _____

8. **Will the student need an inhaler in school? Yes ____ No _____**

If yes, please have the student's primary health care provider/pediatrician complete and sign an Asthma Action Plan. This is required to be updated every 12 months.

**Please plan to bring any emergency medications(s) for the student to the health office in Klee building on the first day of school. Medications should have a proper label and include the medication name, dosage, and instructions; the student's name and date of birth; and the prescriber's name and phone number.*

9. **Does the student wear glasses? Yes ____ No _____**

10. **Does the student have any other vision impairments, such as color "blindness" or color deficiency? Yes ____ No _____**

    If yes, describe: _____

11. **Does the student have a hearing aid? Yes ____ No _____**

12. **Does the student have any other hearing impairments? Yes ____ No _____**

    If yes, describe: _____

13. **Please list any concerns with psychiatric, social, or behavior issues:**

    _____

    _____

    _____

14. **Please list the names and ages of all siblings and indicate if they attend Crossroads Academy:**

    _____

    _____

15. The information on this form may be shared with my child's teachers on a need-to-know basis: **Yes ____ No _____**

Vision Screening

Once a year, the **Lions Club of Hanover** offers free vision screening for all students. It can help to evaluate underlying eye conditions that can impair vision. It is not diagnostic, but can be helpful. The testing is very quick and each student is out of class a minimum period of time, often less than five minutes.

Please indicate if you give the Lions Club permission to perform this screening on your student by completing the attached form. **This permission is required annually**.

Routine hearing and vision testing by the health office staff is not provided as most pediatric or primary care offices are now completing these tests. We are, however, able to complete them on an as-needed basis.

Over the Counter Medications Form

Please indicate with an "X" which over-the-counter (OTC) medications we may administer to your student as needed in the health office. These will be administered by one of the school nurses or a designated staff member who has been determined to be trained at administering medication.

Medication	**Reason it may be used**	**Yes**	**No**
Tylenol *(Acetaminophen)*	Fever, Pain		
Advil or **Motrin** *(Ibuprofen)*	Fever, Pain		
Benadryl *(diphenhydramine)* • Tablets or Liquid	Allergic reaction		
Benadryl *(diphenhydramine)* • Cream	Rash, itch, insect bite		
Hydrocortisone Cream	Rash, itch, insect bite		
Neosporin Ointment *(Bacitracin zinc, neomycin sulfate, Polymyxin B sulfate)*	Wound		
Cough Drop	Cough		
Sting Relief Wipe *(lidocaine, ethyl alcohol, benzalkonium chloride, menthol)*	Bee/wasp/hornet sting		
TUMS *(calcium carbonate)*	Upset Stomach		

Crossroads Academy has Epinephrine pens and Narcan (naloxone) on site and in all buildings to be used in case of emergency. All staff have been trained in their use.

For field trips, these emergency medications are provided for the staff to use as well.

Consent to treat

I give consent for the nurses or designated and trained staff at Crossroads Academy to administer First Aid, routine health assessment, and as-needed over-the-counter or prescription medications to the above student: **Yes** ____ **No** _____

Parent Signature _____ **Date** _____

Parent Name _____

I attest that the above medical information about my child to be true and accurate and will update the Crossroads Academy health office staff of any changes:

Parent Signature _____ **Date** _____

Parent Name _____