11 Children's Way
Rockport, ME 04856

(207)236-7809
FAX (207)236-7820

Chris Walker-Spencer
Principal

Katie Bauer
Assistant Principal

Student Name: _____ Grade:_____

Health Care Provider: _____ Dentist: _____

Does your child have any known medical problems? YES NO
If yes, explain: _____

Has your child had any serious illness, injury or hospitalization in the past year? YES NO
If yes, explain: _____

Has your child ever been diagnosed with a concussion? YES NO
If yes, when: _____

Has your child had any recent emotional upset/mental health concerns? YES NO
If yes, explain: _____

Students Age 7 and Older: Do you give permission for your child to be given cough drops at school if determined necessary by the school nurse? YES NO

Current Medications: Include ALL medications your child is taking (attach list if needed).

Medication	Dose	Reason

Complete the following information as it applies to your child:

Vision: My child wears glasses or contacts: YES NO
List any vision needs at school: _____

Hearing: My child wears hearing aids or other hearing device: YES NO
List any hearing needs at school: _____

*** Asthma:** My child uses an inhaler or nebulizer: YES NO

*** Allergies:** My child is allergic to: _____
My child has an epi-pen: YES NO

***Food Allergies and or Food Intolerances** (please list): _____
_____

***All students with life-threatening allergies or asthma requiring emergency medications must have an annual Action Plan signed by the healthcare provider and parent. Action Plan forms are available on the school website or from the school nurse.**

Phone: Home _____ Work _____ Cell _____

_____ _____ _____
Parent/Guardian Name Signature Date

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