



Rivendell Interstate School District
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2026-2027 Annual Health Update & Emergency Authorization Form

School Attending: Rivendell Academy ☐ Samuel Morey ☐ Westshire ☐

Grade/YOG:

Teacher/Advisor:

Student Name:

Student Date of Birth:

Parent/Guardian to be contacted first:

Preferred phone number:

Alternate phone number:

Contact if Parent/Guardian unavailable:

Phone number:

Health Care Provider and location:

Has your child had a physical exam within last 12 months? Yes ☐ No ☐

Does your child have Health Insurance? Yes ☐ No ☐

Dentist and location:

Has your child had a dental exam within last 12 months? Yes ☐ No ☐

STUDENT'S MEDICAL HISTORY:

Does your child have any of the following (please explain):

Asthma Has a doctor, nurse, or other health professional EVER said that your child has asthma?

Yes ☐ No ☐ Don't know/not sure ☐

If yes, does your child STILL have asthma? Yes ☐ No ☐ Don't know/not sure ☐

Does your child carry an inhaler? Yes* ☐ No ☐ *If yes, provide copy of Asthma Action Plan

Severe allergy Yes ☐ No ☐ EpiPen? Yes ☐ No ☐ Type of reaction:

Medication allergy Yes ☐ No ☐ To what?

Epilepsy/seizure Yes ☐ No ☐ Explain:

Cardiac conditions Yes ☐ No ☐ Explain:

Orthopedic concerns Yes ☐ No ☐ Explain:

Dental problems Yes ☐ No ☐ Explain:

Chronic illness Yes ☐ No ☐ Explain:

Corrective lenses Yes ☐ No ☐ Explain:

Hearing aids Yes ☐ No ☐ Explain:

Assistive devices or other medical equipment: Yes ☐ No ☐ Explain:

Health Concerns: Describe ALL significant health problems/concerns including illnesses, injuries, hospitalizations, disabilities, psychological concerns/stressors:

Medications: Please list ALL medications that your student is currently taking at home or school. Include over-the-counter and prescription medications:

Does your student need to receive prescription or emergency medication during school? Yes ☐ No ☐

*If yes, name of medications:

***All medications need to be brought to school by parent/guardian in the medication's original container, along with a completed Medication Order Form. Notify health office with any questions or if there is a change in ANY of the above information.**

Permission for Over-the-Counter Medications:

My child has permission to receive the following non-prescription medications at school:

- | | |
|--|---|
| ☐ Acetaminophen (Tylenol) | ☐ Triple Antibiotic Ointment |
| ☐ Ibuprofen (Advil/Motrin) | ☐ Anti-Itch Ointment/Lotion/Gel |
| ☐ Benadryl (for allergic reactions) | ☐ Hydrocortisone cream |
| ☐ TUMS antacid | ☐ Orajel (for mouth sores or tooth/gum discomfort) |
| ☐ Cough Syrup | |

Parent/Guardian Signature:

Date:

RELEASE OF INFORMATION (OPTIONAL): I give permission to _____ (healthcare provider) to release and share with the school nurse any information which they deem to be in the best interest of my child _____ (student name), inclusive of immunizations records, medication information, appointment dates, allergies or other health concerns. I also grant permission for the school nurse to release to _____ (healthcare provider) all the information listed above, in addition to any information which they determine to be in the best interest of my child. I acknowledge that I understand the purpose of this request and that authorization is hereby granted voluntarily. I further understand that I may change or revoke this authority at any time in writing.

Name of Student:

Parent/Guardian Signature:

Date:

IN CASE OF AN EMERGENCY INVOLVING MY CHILD, WHEN I CAN NOT BE REACHED:

I hereby give consent for my child to be transported by ambulance for medical care and authorize the providers and hospital to give any reasonable and customary medical and health care deemed necessary at my expense. I understand that I will be financially responsible for all emergency care.

The information on this form may be shared with school staff and emergency personnel as appropriate.

Name of Student:

Name of Parent/Guardian:

Parent/Guardian Signature:

Relationship to Student:

Date: