STUDENT HEALTH AND EMERGENCY INFORMATION FORM

Please complete the following information and return to school immediately. HR#________Grade______

Student's Name____
Last First Middle

Home Phone __________________________ Address_______________________________
(Area Code)

Date of Birth ______________ Sex: F M Primary Language at home _____________
Secondary Language __________________

Does your child have Health Insurance? Yes___ No___ Name of Insurance Co. __________________
(If you do not have Health Insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable health care (restrictions may apply), please contact the school nurse for more information All communication will be confidential.)

Name Mother/Guardian ____________________________ Cell Phone__________________________
Home Address_______________________________________ Home Phone (area code) ________________
Work Address_______________________ Town/City____________ Phone_____________ Ext____
Email address____

Name Father/Guardian______________________________ Cell Phone____________________________
Home Address____ Home Phone (area code) _________________
Work Address_______________________ Town/City____________ Phone_____________ Ext____
Email address____

Name/grade of sisters/brothers in school building: Gr._______ Name________________________
Gr._______ Name________________________

Name of others who will assume responsibility/transportation in the absence of parent/guardian:
Name______________________________ Relationship________________ Phone_______________
Name______________________________ Relationship________________ Phone_______________
(**In case of emergency**, the school will attempt to contact parent/guardian before calling student's primary care provider (physician). Your child will be transported by ambulance to an emergency care facility if necessary)

Physicians Name__________________________________ Phone __________________________
Dentists Name____________________________________ Phone __________________________

List any prescription medication your child takes at home: 1:____________________________
2.___________________________ 3:______________________ 4______________________
(Include inhalers/Insulin/Antidepressants/Cardiac/Behavioral medications etc.)
*__You must have a written physicians order for your child to take medication at school__. This includes prescription medication such as inhalers, Epipens over the counter medication, including cough syrups, nasal sprays, etc. <u>The school nurse will not dispense any medication without a written MD order.</u>

Please check all that applies to you child:
______ Heart Condition ________ Diabetes (Type I Insulin Dependent) _______Asthma
______ Seizure Disorders ________ Migraines _______ADD _____ADHD _____Others
Specify:____

Diabetic, Finger Stick Testing at school? ___ Y __ N (You must provide your own Glucometer)
Allergies: List all/any specific allergies: ____
Identify if your child will have an EPIPEN at school for his/her allergy: _____Y _____N
Hearing and vision: Screenings are done randomly during the school year and your child may or may not be screened. This includes H/V. Identify if your child requires preferred seating ______Y _______N
Hearing Aids: ___________ Other___________

I give permission to the school nurse/designee to share information relevant to my child's condition with appropriate personnel when needed to meet my child's health and safety needs.
I give permission to exchange information with my child's primary care physician for purpose of referral, diagnosis and treatment.
A CURRENT PHYSICAL EXAM REPORT SHOULD BE ON FILE AT ALL TIMES.
PARENT/GUARDIAN SIGNATURE:_________________________________ DATE:___________