

STUDENT HEALTH AND EMERGENCY INFORMATION FORM

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

Student's Name _____

Home Phone _____ Last _____ First _____ Middle _____
(Area Code) Address _____

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. The school nurse will not dispense any medication without a written MD order.

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: _____