STUDENT HEALTH AND EMERGENCY INFORMATION

PLEASE COMPLETE BOTH PAGES OF THIS FORM AND RETURN THEM TO THE SCHOOL.

PLEASE ADVISE SCHOOL OF ANY CHANGES TO THIS INFORMATION DURING THE COURSE OF THE SCHOOL YEAR

STUDENT'S LAST NAME:_____FIRST:_____MIDDLE:_____

GRADE:_____ HOMEROOM:_____ DATE OF BIRTH:_____GENDER: ☐MALE ☐FEMALE ☐NON-BINARY

STUDENT'S ADDRESS:_____

MAILING ADDRESS (IF DIFFERENT):_____

TYPE OF INSURANCE: ☐ PUBLIC (i.e. Mass Health, other) ☐ PRIVATE (i.e. BCBS, Tufts, Health New England, other)

STUDENT LIVES WITH: ☐ BOTH PARENTS ☐ MOTHER ☐ FATHER ☐ LEGAL GUARDIAN

TRANSPORTATION TO SCHOOL: ☐ PARENT DRIVES ☐ STUDENT WALKS ☐ SCHOOL BUS #_____

TRANSPORTATION FROM SCHOOL: ☐ PARENT DRIVES ☐ STUDENT WALKS ☐ SCHOOL BUS #_____

STUDENT GOES TO REC CENTER IN: ☐ AM ☐ PM ☐ BOTH AM & PM

STATE ORDER OF PREFERENCE FOR CALLS BY PUTTING A NUMBER ON EACH LINE BELOW:

_____MOTHER/GUARDIAN:_____PHONE#: _____

ADDRESS:_____

ALT. PHONE#:_____EMAIL: _____

_____FATHER/GUARDIAN:_____PHONE#: _____

ADDRESS:_____

ALT. PHONE#:_____EMAIL: _____

Name of others who may provide assistance/transportation to your child during the school day if you are not available:

FIRST CHOICE CONTACT:_____PHONE #:_____

RELATIONSHIP TO STUDENT:_____

SECOND CHOICE CONTACT:_____PHONE#:_____

RELATIONSHIP TO STUDENT:_____

Are there any court-mandated custody/visitation orders limiting access to this student? Y ☐ N ☐

SIBLINGS IN THE SCHOOL DISTRICT:

_____GRADE:_____

_____GRADE:_____

It is agreed that your signature authorizes the school to take whatever emergency medical action it deems necessary, at your own expense, if the above contacts are not available. In case of an 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. Only those people listed here have permission to dismiss your child from school.

BY MY SIGNATURE BELOW I CERTIFY THAT THE ABOVE NAMED STUDENT IS A LEGAL RESIDENT OF THE TOWN OF _____

SIGNATURE OF PARENT/LEGAL GUARDIAN:_____ DATE:_____

PLEASE COMPLETE PAGE 2

STUDENT HEALTH INFORMATION

PLEASE ANSWER THESE HEALTH QUESTIONS ABOUT YOUR CHILD. *Please explain all "YES" answers in the space below.*

Any health concerns	Y ☐	N ☐		Any broken bones/dislocations	Y ☐	N ☐	
Allergies to food or bee stings	Y ☐	N ☐		Any muscle or joint injuries	Y ☐	N ☐	
Allergies to medication	Y ☐	N ☐		Any neck or back injuries	Y ☐	N ☐	
Any other allergies	Y ☐	N ☐		Problems running	Y ☐	N ☐	
Any daily medications (list below)	Y ☐	N ☐		"Mono" (past 1 year)	Y ☐	N ☐	
Any problems with vision, glasses/contacts	Y ☐	N ☐		Has only 1 kidney or testicle	Y ☐	N ☐	
Any problems hearing	Y ☐	N ☐		Excessive weight gain/loss	Y ☐	N ☐	
Any problems with speech	Y ☐	N ☐		Concussion	Y ☐	N ☐	
ADHD/ADD	Y ☐	N ☐		Fainting or blacking out	Y ☐	N ☐	
Dental braces, caps, or bridges	Y ☐	N ☐		Chest pain	Y ☐	N ☐	
Diabetes	Y ☐	N ☐		Heart problems	Y ☐	N ☐	
Problems breathing or coughing	Y ☐	N ☐		High/Low blood pressure	Y ☐	N ☐	
History of Asthma	Y ☐	N ☐		Bleeding more than expected	Y ☐	N ☐	
Asthma treatment (past 3 years)	Y ☐	N ☐		History of Seizures/Epilepsy	Y ☐	N ☐	
Anyone smoke in the home	Y ☐	N ☐		Hospitalization or Emergency Room visit	Y ☐	N ☐	

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

_____

_____

_____

These products shall be used: Benadryl cream, Calamine/Caladryl lotion and triple antibiotic ointment as per the nursing procedures on file.

Does the student require: EPI-PEN ☐ YES ☐ NO ASTHMA INHALER ☐ YES ☐ NO

Will an EPI-PEN or asthma inhaler be kept at the school? ☐ YES ☐ NO

If the student will require an EPI-PEN or asthma inhaler at school, doctor's orders will need to be submitted to the school nurse. Doctor's orders are also needed if the student self-carries an EPI-PEN and/or asthma inhaler.

Please list any **medications** your child will need to take **in** school:

_____

_____

All medications taken in school require a separate Medication Authorization Form signed by a health care provider and parent/guardian.

Allergist:_____Phone #: _____

Physician:_____Phone #:_____

Dentist:_____Phone #: _____

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. I also give permission to exchange information with my child's health care provider, for the purpose of referral, diagnosis, treatment and well-being.

SIGNATURE OF PARENT/LEGAL GUARDIAN:_____ DATE:_____

OVER-THE-COUNTER MEDICATION PERMISSION

This form is to be filled out by parent or legal guardian for students in Grades 6 – 12 ONLY

Over-the-counter medications will not be dispensed to students in grades PreK – Grade 5.

STUDENT'S NAME:_____ GRADE:_____

I give permission for the School Nurse to administer the following over-the-counter (OTC) medications to my child according to the established protocols. **I have crossed out and initialed any products that I do not wish my child to receive.** These products shall be used, Benadryl cream, Calamine/Caladryl lotion and triple antibiotic ointment as per the nursing procedures on file.

Acetaminophen (Tylenol)	Tablets - (grades 6 - 12 students) As needed for minor discomfort, headache, menstrual cramps, musculoskeletal pain, etc. *School Nurse may limit frequent administration of Tylenol.*
Benadryl	Liquid dosage for Emergency use only
Ibuprofen	Tablets - (12 years and older) As needed for menstrual cramps, minor discomfort, headache, musculoskeletal pain, dental pain, etc. *School Nurse may limit frequent administration of Ibuprofen.*
Tums (antacid)	As needed for minor gastric distress or indigestion.

All other medications require a written doctor's order and a written parental permission. Please contact the school nurse for additional information and the proper forms.

To the best of my knowledge, my child has no allergy/sensitivity to any of the above named products.

SIGNATURE OF PARENT/LEGAL GUARDIAN:_____ DATE:_____