STUDENT HEALTH AND EMERGENCY INFORMATION

PLEASE COMPLETE THE ENTIRE FORM AND RETURN IT 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:_____ EMAIL: _____

EMPLOYER:_____PHONE#: _____

_____FATHER/GUARDIAN:_____PHONE#: _____

ADDRESS:_____ EMAIL: _____

EMPLOYER:_____PHONE#: _____

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:_____

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	Y ☐	N ☐		"Mono" (past 1 year)	Y ☐	N ☐	
Any problems with vision	Y ☐	N ☐		Has only 1 kidney or testicle	Y ☐	N ☐	
Uses contacts or glasses	Y ☐	N ☐		Excessive weight gain/loss	Y ☐	N ☐	
Any problems hearing	Y ☐	N ☐		Concussion	Y ☐	N ☐	
Any problems with speech	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 ☐	
ADHD/ADD	Y ☐	N ☐		High blood pressure	Y ☐	N ☐	
Problems breathing or coughing	Y ☐	N ☐		Bleeding more than expected	Y ☐	N ☐	
Any smoking	Y ☐	N ☐		Seizure treatment (past 2 years)	Y ☐	N ☐	
Asthma treatment (past 3 years)	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.

_____

_____

_____

Is there anything you want to discuss with the school nurse? Y ☐ N ☐ If yes, explain:

_____

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:_____