STUDENT HEALTH AND EMERGENCY INFORMATION FORM

School Year 2020-2021

Student's Name_____ ID # _____ Shop _____ Week_____
Year of Graduation _____ Date of Birth _____/_____/_____
Primary Language at home _____ Secondary Language _____
Does your child have Health Insurance? Yes ___ No___ Name of Insurance Co. _____

If you have no 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 about these programs. (508-678-2891 x 1770 or x1771) All communications will be kept confidential.

Is your child <u>currently</u> under a doctor's care for any of the following conditions? If any question is answered with "YES", please explain in the space below. ***<u>PLEASE ANSWER ALL QUESTIONS:</u>***

ADD/ADHD	YES	NO	VISION HEARING PROBLEMS	YES	NO
Does your child require an inhaler at school? * If yes, doctor's order, parent permission and medication ***MUST*** be turned into the nurses' office on the first day of school.	**YES**	**NO**	**BONE/JOINT DISEASE OR INJURY**	**YES**	**NO**
DIABETES	**YES**	**NO**	**HEART PROBLEMS**	**YES**	**NO**
SEIZURES	**YES**	**NO**	**EMOTIONAL CONCERNS**	**YES**	**NO**
ALLERGIES	**YES**	**NO**	**List allergies:** **Does your child require an epi pen?*** If yes, doctor's order, parent permission and medication ***MUST*** be turned into the nurses' office on the first day of school.	**YES**	**NO**
Other concerns/comments:					

In case of emergency, the school will attempt to contact parent/guardian before calling student's primary care provider. Your child will be transported by ambulance to an emergency care facility if deemed necessary.

Physicians Name_____ Phone _____

Dentists Name_____ Phone _____

Preferred Hospital _____

****CONTINUED ON REVERSE SIDE****

Please list all medications your child takes at home (Include inhalers/insulin/antidepressants/cardiac/behavioral medications etc.)

Medication	Dose	Time	Reason

You must have a written physicians order for your child to take medication at school. This includes prescription medication such as inhalers, Epipens and all over the counter medications. The school nurse will not dispense any medications without the proper documentation on file. All medications should be prescribed outside of school hours when possible.

I give permission to the school nurse to treat my child and 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.

*****I UNDERSTAND THAT A CURRENT PHYSICAL EXAM REPORT SHOULD BE ON FILE AT ALL TIMES AND IS <u>REQUIRED</u> FOR ALL INCOMING FRESHMAN AND TRANSFER STUDENTS, ALONG WITH APPROPRIATE STATE MANDATED IMMUNIZATIONS . STUDENTS WITH PRESCRIBED EMERGENCY MEDICATIONS WILL NOT BE ALLOWED TO ATTEND FIELD TRIPS IF MEDICATIONS, ORDERS, AND PARENT PERMISSIONS ARE NOT ON FILE WITH THE NURSE*****

PARENT/GUARDIAN SIGNATURE:_____ DATE:_____

EMERGENCY CONTACT INFORMATION:

Mother/Guardian _____ Cell #_____ Home # _____ Other # _____

Father/Guardian_____ Cell #_____ Home # _____ Other # _____

Name of others who will assume responsibility/transportation in the absence of parent/guardian:

Name_____ Relationship_____ Cell# _____ Home #_____

Name_____ Relationship_____ Cell #_____ Home #_____

Name_____ Relationship_____ Cell #_____ Home #_____

Name_____ Relationship_____ Cell #_____ Home #_____