STUDENT HEALTH AND EMERGENCY INFORMATION FORM **School: circle HS/MS**

Complete the following and return to school immediately. Contact School Nurse if you have questions with this form.

Student name_____ Grade_____
Last First Middle

Address_____ Student's Primary Language _____
No. Street

Home Phone_____Gender_____Date of Birth_____

Does child have health insurance? Circle Yes / No Name of Insurance Company_____

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. All communication will remain confidential

Mother/Guardian name (printed)_____
E-Mail Address_____ Home Address_____
Work Phone_____ Cell Phone_____

Father/Guardian name (printed)_____
E-Mail Address _____Home Address_____
Work Phone _____Cell Phone_____

IN CASE OF EMERGENCY AND NEITHER PARENT CAN BE REACHED, PLEASE LIST TWO NAMES AND PHONE NUMBERS OF RELATIVE OR FRIEND WE MAY CONTACT WHO WILL ASSUME TEMPORARY CARE OF YOUR CHILD.

EMERGENCY NAME_____Relationship_____
Home Phone _____Cell Phone_____

EMERGENCY NAME_____Relationship_____
Home Phone _____ Cell Phone_____

Physician's Name_____Phone_____
Dentist's Name_____Phone_____

Please list all the medications that your child takes _____
_____

Please check all that applies to your child:
□ Heart condition □ Diabetes □ Asthma □ Seizure Disorder □ ADD/ADHD □ Migraines □ Depression
Other_____

Allergies (food, insects, medication, environment, (specify)_____
Does your child have an EpiPen? □Yes □No

Any other conditions that the School Nurse should know about? _____

Does your child: □ wear glasses □ wear contact lenses □ wear a hearing aid □ other corrective device

I give my permission for the school nurse to administer: □ Acetaminophen □Ibuprofen

Parent/Guardian signature_____Date_____

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 give permission to exchange information with my child's physician/counselor for the purpose of referral, diagnosis and treatment.

Parent/Guardian signature_____Date_____

I, the undersigned, as parent/guardian of the above named minor child, do hereby permit the hospital and its physicians to perform on this child any procedures or treatment as may be deemed necessary in emergency situation.

Parent/Guardian signature_____Date_____