SCHOOL NURSE'S STUDENT HEALTH AND EMERGENCY INFORMATION

School__________________

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

Student's name ____ D.O.B.________________ Sex ____________ Grade __________

Address ____________________________________Home Phone ________________________ Parent E-mail Address ____________________________

Mailing Address if different than above ____ Student's Primary Language _____________________

Is your child covered by Health Insurance ________Yes ________No Insurance Company__________________ Policy # __________________

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/Other __________________________________ Home Address ____

Work Address _____________________________________ Work Phone ________________________ Cell Phone ________________________

Father/Guardian/Other ___________________________________ Home Address ____

Work Address _____________________________________ Work Phone ________________________ Cell Phone ________________________

Emergency contacts if parents/guardians cannot be reached in emergency. If your child is ill and you are unavailable, shall the school allow this person to sign your child out of school?

____ _______Yes _______ No
Name Phone Dismiss to care of this person?

____ _______Yes _______ No
Name Phone Dismiss to care of this person?

____ _______Yes _______ No
Name Phone Dismiss to care of this person?

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

____ ______________________________
Physicians Name Physician's Phone

____ ______________________________
Dentist's Name Dentist's Phone

Please list all medications that your child takes____

____

Please check all that apply to your child

☐ Heart condition ☐ Diabetes ☐ Asthma ☐ Seizure disorder ☐ ADD/ADHD ☐ Migraines

☐ Depression ☐ Other (specify) ____

Known Allergies ____

Any other conditions that School Nurse should know about? ____

Does your child ☐ wear eyeglasses? ☐ wear contact lenses? ☐ wear a hearing aid ? Other corrective device? ___________________

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 primary care physician 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 an emergency situation.

____ ____________________
Parent/Guardian Signature Date