STUDENT HEALTH AND EMERGENCY INFORMATION FORM

FILL OUT IN BLACK OR BLUE PEN ONLY

Student name _____
Last First Middle (full middle name)

Address _____
No. Street Town Zip code

Home Phone _____ Gender _____ Date of Birth _____

Language spoken at home _____ Place of Birth _____

Does child have health insurance? Yes _____ No _____

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 is confidential!

Parent 1/Guardian name (print) _____

Home Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Pager _____

Parent 1 Signature _____

Parent 2/Guardian name (print) _____

Home Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Pager _____

Parent 2 Signature _____

IN CASE OF EMERGENCY AND NEITHER PARENT CAN BE REACHED, PLEASE LIST NAME AND PHONE NUMBER OF RELATIVE OR FRIEND WE MAY CONTACT.

EMERGENCY NAME _____ Relationship _____
Home Phone _____ Work Phone _____ Cell Phone _____

Physician's Name _____ Phone _____
Dentist's Name _____ Phone _____
Hospital of Choice _____ (EMT or Paramedic may override choice)

Please check all that applies to your child:
Heart condition ____ Diabetes ____ Asthma ____ SeizureDisorder ____ ADD/ADHD ____ Migraines ____ Depression ____
Other (specify) _____

Allergies (food, insects medication, environment, (specify) _____
Does your child have an EpiPen? Yes _____ No _____
Hearing Problems (specify) right ear _____ left ear _____
Vision Problems (specify) _____

I give my permission for the school nurse to administer Tylenol or ibuprophen to my child.
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 primary care physician for the purpose of referral diagnosis and treatment.
Parent/Guardian signature _____ Date _____