STUDENT HEALTH AND EMERGENCY INFORMATION FORM
FILL OUT IN BLACK OR BLUE PEN ONLY

Student name_____ Grade_____
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? 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 is confidential!

PLEASE INDICATE THE NUMBER TO CALL IN ORDER TO REACH SOMEONE IMMEDIATELY

Parent1/Guardian name (printed)_____

Home Address_____

Home Phone_____ Work Phone_____

Cell Phone_____ E-mail Address_____

Signature_____

Parent2/Guardian name (printed)_____

Home Address_____

Home Phone_____ Work Phone_____

Cell Phone_____ E-mail Address_____

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_____
Medications/Other_____

Allergies (food, insects medication, environment, (specify)_____
Does you child have and EpiPen? Yes_____ No_____
Hearing Problems (specify) right ear_____ left ear_____
Vision Problems (specify)_____

I give my permission for the school nurse to administer Acetaminophen/Ibuprofen to my child. _____yes _____no
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. _____yes _____no

Parent/Guardian signature_____ Date_____