Ware Public Schools—Health Services

School Year 2018 – 2019
Student Information

Name _____ **Date of Birth** _____ **Male / Female**
Last First (circle one)

Street Address_____ **Town** _____

Mailing Address (if diff) _____ **Home phone** (_____) _____

Preferred Primary Contact for All School Health Matters
(MUST be parent/guardian with actual physical custody)

Name _____ Daytime location _____

Relation _____ phone # (_____) _____

Alternate / Cell # (_____) _____

Secondary Contact for Urgent School Health Matters
(Responsible ADULT able to bring student home or to a hospital or physician's office for medical attention)

Name _____ Daytime location _____

Relation _____ phone # (_____) _____

Alternate / Cell # (_____) _____

I understand school personnel will contact me in case my child is seriously ill or injured. In an emergency, school personnel may arrange for my child to be transported to a hospital for medical care not available at the school. Regardless of age over or under 18, my child will not be dismissed alone (or with an emergency contact) without my specific consent for any non-emergent reasons.

Parent/Guardian signature _____ **Date** _____

Please contact the School Nurse if there are any changes
to the student's information during the course of the school year.

SIGN BELOW FOR THIS STUDENT TO RECEIVE OVER-THE-COUNTER (OTC) MEDICATIONS AT SCHOOL.
I give permission for the School Nurse to administer the following medications as necessary ***(call Nurse for specific concerns)****:*

FOR PAIN/DISCOMFORT Acetaminophen (i.e. Tylenol) Ibuprofen (i.e. Advil/Motrin)
These medications may also be given for fever over 101 F if dismissal will be delayed and student is very uncomfortable.

FOR ALLERGIES Diphenhydramine (i.e. Benadryl)

FOR SORE THROAT/COUGH Throat lozenges **FOR WOUNDS** Antiseptic Liquid (i.e. Bactine)

FOR SKIN Cooling Burn Cream or Gel Calamine Lotion Caladryl Lotion Hydrocortisone Cream

FOR UPSET STOMACH Antacid/Anti-Gas (i.e. TUMS/Mylanta) **FOR GUM/TOOTH PAIN** Anbesol Orajel

I understand the School Nurse may decline to administer an OTC medication if, in his / her judgment, other relief measures should be attempted first or if further medical evaluation may be needed for the symptoms. I also understand, by MA General Laws, oral OTC medications CANNOT be given by ANY school personnel except a School Nurse regardless of parent request or consent.

Parent/Guardian signature _____ **Date** _____

COMPLETE HEALTH INFORMATION ON BACK OF FORM

Rev 5/2018

Ware Public Schools—Health Services

Health Information

Name_____ **Gr.** _____ **Teacher** (homeroom) _____

Date of Last Physical Exam _____ Physician's Name_____
Problems found _____ Town_____Phone (_____)_____

Date of Last Dental Exam _____ Dentist's Name_____
Problems found_____ Town_____Phone (____)_____

Date of Last Eye Exam _____ **Glasses / Contacts:** FULL TIME / DISTANCE / READING
(NOT school vision screening) (Circle how glasses used)

Health Insurance _____ If student does not have ANY Health Insurance coverage, write: "NONE"
(NAME of insurance only)

Check ONE Column to RIGHT and COMMENT, if applicable

Health History (describe & note any medications currently used for this problem)	**Never**	**Past** (no concerns in 2+ years)	**Recent** (new concern in past year)	**Ongoing** (persistent over 1 year)
Allergic reactions **(specify below)				
Asthma				
Chickenpox				
Diabetes (type)				
Fainting				
Fractures / Dislocations / Sprains **(specify below)				
Frequent headaches/Migraines **(specify below)				
Heart Problems				
Kidney or urination problems				
Major Head / Neck / Back injury				
Psych / Emotional / Behavioral Concern **(specify below)				
Seasonal allergies				
Seizures *(please specify below)				
Skin problems **(specify below)				
Stomach / bowel problems **(specify below)				
Other (specify)				
**				
**				
**				

Seen by MD or in ER in past 3 months FOR URGENT OR EMERGENCY CARE? (reason / recommendations) _____

_____

Hospitalizations / Operations (explain) _____

Seen by a specialist? (specify reason and name of doctor) _____

What prescription medication(s) does he / she take at home? (reason?) _____

_____
(If any medication must been taken during school hours, contact the School Nurse to arrange for a physician's order.)

Additional Comments _____

The School Nurse may communicate with other individuals (teachers, administration, physician, medical personnel) working with my child regarding his/her health. Any information will be given ONLY for the purpose of protecting or promoting health or providing appropriate educational services. The School Nurse may receive from my child's medical care provider any medical information necessary to provide school health services for my child.

Parent/Guardian signature _____ **Date** _____

TURN PAGE OVER AND COMPLETE STUDENT / CONTACT INFORMATION

Rev 5/2018