*Student Information*

Name: Date of Birth: / /

 Last First

[ ]  Male [ ]  Female Grade: Homeroom Teacher:

Residential Address: Phone Number:

Mailing Address (if different):

Preferred Primary Contact for All School Health Matters

(MUST be parent/guardian with actual physical custody)

Name: Relation:

Daytime Location:

Phone Number: Alternate/Cell Number:

Secondary Contact for Urgent School Health Matters

(Responsible ADULT able to bring student home or to a hospital/physician’s office for medical attention)

Name: Relation:

Daytime Location:

Phone Number: Alternate/Cell Number:

*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 express 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 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 101o F if dismissal will be delayed and student is very uncomfortable*

FOR ALLERGIES

Cetirizine (i.e. Zyrtec)

FOR SORE THROAT/COUGH

Throat lozenges

FOR SKIN

Cooling Burn Cream or Gel

Calamine Lotion

Caladryl Lotion

Hydrocortisone Cream

FOR WOUNDS

Antiseptic Liquid (i.e. Bactine)

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; this includes during field trips, after-school programs, or other school-sponsored events.*

Parent/Guardian Signature: Date:

***Health Information***

 Physician’s Name Town Phone

 Date of Last Physical Problems Found

 Dentist’s Name Town Phone

 Date of Last Dental Exam Problems Found

 Contacts/Glasses: YES/NO

 Date of Last Eye Exam If yes, glasses are used for: [ ]  Full Time [ ]  Distance [ ]  Reading

 *(NOT school vision screening)*

Health Insurance (NAME of insurance only):

*If student does not have ANY Health Insurance coverage, write: “NONE*”

**Check ONE Column to the RIGHT and COMMENT, if applicable**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Health History***Describe & note any medications**currently used for problem* | **Never** | **Past***no concern in 2+ years* | **Recent***new concern in past year* | **Ongoing***persistent over 1 year* |
| Allergic reactions (medication, food, insect, environmental or latex) |  |  |  |  |
| Asthma  |  |  |  |  |
| Chickenpox/Mononucleosis |  |  |  |  |
| Diabetes |  |  |  |  |
| Ear Infections |  |  |  |  |
| Fainting Seizures |  |  |  |  |
| Fractures/Dislocations/Sprains |  |  |  |  |
| Frequent headaches |  |  |  |  |
| Heart Problems/Murmurs |  |  |  |  |
| Kidney or urination problems |  |  |  |  |
| Major Head/Neck/Back injury |  |  |  |  |
| Psych/Emotional/Behavioral Concern |  |  |  |  |
| Respiratory infections |  |  |  |  |
| Seasonal allergies |  |  |  |  |
| Skin problems/rashes |  |  |  |  |
| Stomach/bowel problems |  |  |  |  |
| Throat problems |  |  |  |  |
| Other (specify) |  |  |  |  |
| Other (specify) |  |  |  |  |

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

Hospitalizations/Operations (explain)

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

What prescription medication(s) does he/she take on a regular basis? (reason)

(If any medication must be 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: