Ware Public Schools – Health Services

School Year 20____ - 20____

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 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 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: _____

COMPLETE HEALTH INFORMATION ON OTHER SIDE

Ware Public Schools – Health Services

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 _____

Date of Last Eye Exam *(NOT school vision screening)* _____

Contacts/Glasses: YES/NO
If yes, glasses are used for: ☐ Full Time ☐ Distance ☐ Reading

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 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: _____

COMPLETE STUDENT/CONTACT INFORMATION ON OTHER SIDE Rev. 3/22/19