Student I.D. #_____ **Teacher/Grade: _____**

STUDENT HEALTH AND EMERGENCY INFORMATION FORM
2017 - 2018

Please complete the following information and return to school immediately. Contact school nurse if assistance is needed to complete form.

Student's Name _____
Last First Middle
Address _____

Home Phone _____Grade _____ Sex _____DOB: _____ Primary Language_____

Does your child have Health Insurance? _____ Yes _____ No
Health Insurance Company: _____

If you have no health insurance, the Commonwealth of Massachusetts has health insurance plans that will provide uninsured children with affordable health care (Restrictions may apply). If you are interested in more information about this program, please contact the school nurse. All communications will be confidential

Mother/Guardian/Other: _____ Home Address: _____
Place of Employment: _____Work Address: _____

Home Telephone: _____ **Work Telephone:** _____ **Cell Telephone:** _____

Father/Guardian/Other: _____ Home Address: _____
Place of Employment: _____Work Address: _____

Home Telephone: _____ **Work Telephone:** _____ **Cell Telephone:** _____

Name and Grade of sisters/brothers in school building: _____

Please indicate names of friend/relative/neighbor who will assume responsibility and provide transportation for your child in case of illness/injury/emergency evacuation:

Name: _____ Relationship: _____ Daytime Phone: _____

Name: _____ Relationship: _____ Daytime Phone: _____

In case of emergency, the school will attempt to contact parent/guardian before calling student's primary healthcare provider (physician). Your child will be transported by ambulance to an emergency care facility if deemed necessary.

Physician Name: _____ Telephone Number: _____ Date of Last Examination: _____
Dentist Name: _____ Telephone Number: _____ Date of Last Examination: _____

Please list all medications that your child is on: _____

To better serve your child's medical/physical/emotional/educational/social needs, please check the following that pertain to your child:

___ Heart Condition ___ Diabetes ___ Asthma ___ Seizure Disorder ___ ADD/ADHD
___ Migraines ___ Depression ___ Other (Specify) _____
___ Allergies: *To what? (food, insects, medication, environment, other*) Specify _____
___Epi-Pen

Does your child have hearing problems? _____ Yes _____ No Left ear? _____ Right ear? _____ Hearing Aid(s)? _____
Does your child have vision problems? _____ Yes _____ No Eyeglasses? _____ Contact Lens? _____

I understand that this information is confidential. However, federal law permits information in the school health records to be shared with school officials on a "need to know" basis and with a very limited number of other persons, including those who could help in an emergency. In other circumstances, my consent will be required**. I give permission for the exchange of information between my child's healthcare provider and the school nurse.**

Parent/ Guardian Signature: _____ Date: _____