MELROSE PUBLIC SCHOOLS - CONFIDENTIAL STUDENT HEALTH AND EMERGENCY INFORMATION

Student's Name: _____ Grade:_____
Last/First/Middle

Address:_____

Date of Birth: _____ Sex: Male/Female Primary Language: _____

Resides With: _____ Home Telephone: _____

Parent/Guardian #1 Name: _____ Home Telephone: _____

Parent/Guardian #1 Work Telephone: _____Cell Telephone: _____

Parent/Guardian #2 Name: _____ Home Telephone: _____

Parent/Guardian #2 Work Telephone: _____Cell Telephone: _____

Does your child have health insurance? Y N (circle one) Private or Public (circle one)

Health Insurance Company _____ Policy # _____

If you don't have health insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable health care (restrictions may apply). Please contact your school nurse for more information about these programs. All communications are confidential.

Name and grade of siblings in Melrose Schools: _____

Does your child attend a before or after school program or have a sitter? (Y / N) If yes, please provide the contact name and telephone number: _____

In case of an emergency or illness and we are unable to reach the contacts above, please list alternative contacts who will assume responsibility and transportation:

Name: _____ Relationship: _____ Telephone: _____

Name: _____ Relationship: _____ Telephone: _____

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

Physician's Name: _____ Telephone Number: _____

Dentist's Name: _____ Telephone Number: _____

How often does your child visit the dentist? ____ once a year ____ twice a year ___ has never been to a dentist

List <u>all</u> medications that your child takes: _____

I give the school nurse permission to administer the following when appropriate (circle the medications that you agree with): Acetaminophen (Tylenol) / Diphenhydramine Hydrochloride (Benadryl) (insect bites/stings) / Ibuprofen (grade 6-12 only) / Cough Drops (grades 5 & over)

Please circle all the following that apply to your child: History of Concussion – Yes/No How many? _____

Heart Condition Diabetes Asthma Seizure Disorder ADHD/ADD

Migraines Depression Freq. Ear Infections Kidney Disease Rheumatic Fever

Speech Problems (specify) _____

Hearing Problems (specify) _____

Vision Problems (specify) _____

Allergies (specify – food, environment, medication, insect) _____

Other (specify) _____

I give permission to the school nurse to share this 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 primary care physician for the purpose of referral, diagnosis and treatment.

Signature of Parent/Guardian: _____ **Date:** _____