Student Emergency and Health Form

Student (LAST, First): _____ **DOB:** _____ **Advisor:** _____

Address: _____ City: _____ Zip:_____

Parent/Guardian #1: _____ ☐ **check if same address as student**

Address (if different): _____ City: _____ Zip: _____

Home#: _____ Cell#: _____ Work#: _____Ext:_____

Email: _____ Employer: _____

Parent/Guardian #2: _____ ☐ **check if same address as student**

Address (if different): _____ City : _____Zip: _____

Home #: _____ Cell#: _____ Work#: _____ Ext:_____

Email: _____ Employer: _____

With whom does the student reside? _____

Address & Phone# if different than above: _____

Primary language spoken at home: _____

Siblings

Name	Age	School

Emergency Contacts: This is a local person to be notified in case of emergency or illness, when you are unable to be reached. Your child will only be released to those listed below.

Name	Relationship	Home #	Cell #	Work #

Health History:

Life-Threatening Allergies

Indicate if your child has a *physician verified* allergy to any of the following. If yes, please provide official documentation by your child's physician and an **Emergency Care Plan** to the school nurse at the beginning of the school year. Written prescriptions are required for EpiPens, Benadryl, and Inhalers.

Bee Stings ☐ Peanuts ☐ Tree Nuts ☐ Latex ☐ Food ☐ (please specify):_____

☐ Other_____ **Describe your child's allergic reaction:** _____

Is EpiPen required? Yes ◯ No ◯ Is Benadryl required? Yes ◯ No ◯

Has EpiPen ever been used? Yes ◯ No ◯ Does your child carry his/her own Epi Pen? Yes ◯ No ◯

OTHER ALLERGIES (NOT life-threatening - Please check)

Lactose Intolerance ☐ Celiac Disease ☐ Latex Allergy ☐

Other Allergies? (please list)_____

Describe Reaction_____ Medication used for symptoms:_____

Illness/Chronic Conditions:

Please list any illness or conditions your child is being treated for (asthma, ADHD, etc.):

_____

Does your child have any dietary restrictions?_____

Does your child have any physical limitations?_____

Student (Last, First):_____ DOB: _____

Please add any information regarding your child's physical or emotional status which may help us make their education more productive:_____

Medications:

Name of medication	Dosage	When is medication taken?	Side effects

Note: All Prescription and some over-the-counter medications which your child must take at school require an MD/NP/PA order – please refer to the Medication Policy for details.

Vision: Eyeglasses? Yes ◯ No ◯ Contact lenses? Yes ◯ No ◯ Date of last eye exam:_____

Dental: Dental Insurance? Yes ◯ No ◯ Do benefits include: Fluoride ☐ Cleanings ☐ Sealants ☐

Does your child visit the dentist every six months? Yes ◯ No ◯ Date of last exam?_____

Does your child wear braces/dental appliance? Yes ◯ No ◯

Health Care Provider Information:

Physician: _____

Name Address City Zip Telephone

Dentist: _____

Name Address City Zip Telephone

Health Insurance: Name of company _____ Mass Health ☐ No insurance ☐

Subscriber:_____Policy Number:_____ Hospital Preference:_____

Confidential Information: I grant permission to the school nurse to share health information about my child, on a need to know basis with teachers/coaches. Yes ◯ No ◯ Initials:_____ (Sign if printed)_____

Medical Release I grant to the Parker School District personnel the right to obtain emergency medical treatment for my child during the period of the school year. I give permission for ambulance transport to the nearest hospital. Payment for any and all medical treatment is the financial responsibility of the parent/guardian. Yes ◯ No ◯ Initials:____ (Sign if printed)_____

Health Care Provider Release I grant the school nurse permission to exchane information with my child's health~ care provider. I understand that I can limit or revoke this consent at any time. Yes ◯ No ◯ Initials:_____ (Sign if printed)_____

Medication Administration Permission: The school physician allows the school nurse to administer over-the-counter (OTC) medications listed below. These medications do not require a physician's order. All other medications require a written physician's order. My child has permission to take the following OTC medications or generic substitutions (**please check**): **Acetaminophen (Tylenol)** ☐ **Ibuprofen (Motrin)** ☐ **Antacid (Tums)** ☐ **Diphenhydramine(Benadryl)** ☐ **Ceterizine (Zyrtec)** ☐ **Loratadine (Claritin)** ☐

(Limited quantities of seasonal allergy medications are available and only supplied if forgotten at home). Please Note: The above OTC medications may only be given once during the school day. **Hand sanitizer** ☐ **(at least 60% ethanol or 70% isopropanol) as needed.**

Also, the school nurse may use first aid treatments, including topical medications, to treat allergies, rashes, insect bites, toothaches, minor wound infections, and minor burns unless otherwise indicated by parent/guardian.

Yes ◯ No ◯ Initials:____ (Sign if printed)_____

Interscholastic Sports Permission: I give my son/daughter permission to participate in interscholastic activities and to accompany the team as a member on it's off-campus trips. In case of illness or injury, every effort will be made to contact parents/guardians listed above. In the event of an emergency that requires immediate medical attention, I give permission to delegated school officials to secure proper treatment, including transportation via ambulance to the nearest medical facility, the administration of anesthesia and any other necessary medication to my child as determined by healthcare providers. I hereby waive on behalf of the above named child and myself of any liability of the Parker Charter School, any of its agents or employees, arising out of such treatment. Please note: Your child must also have a current physical exam (valid for 13 months to the day of the physical). Students with expired physicals will be ineligible to particpate until a current physical is submitted. The physical must be signed by a licensed MD/NP/PA and on file with the school nurse before participation in any interscholastic sport. Also, by electronically signing this document, you are guaranteeing that your child has health insurance coverage. Any injuries resulting from participation in such such activities will be the responsibility of your child's health insurance coverage. Yes ◯ No ◯ **Initials: ____ (Sign if printed)**_____

Date Completed:_____

mm/dd/yyyy