



**Illness/Chronic Conditions:**

Please list any illnesses your child is being treated for: \_\_\_\_\_

Does your child have any dietary or physical limitations: \_\_\_\_\_

(Please note that a note from your child’s physician is required to excuse a child from any school activity, including physical education.)

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

**Medications:** Please list prescription and over the counter medications your child takes. Include herbal treatments.

Name of Medication & Dose	Reason	Home	School

Note: All Prescription and some over-the-counter medications which your child must take at school require an MD/NP 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 Town Zip Telephone

Dentist: \_\_\_\_\_  
Name Address Town 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 his/her teachers and coaches. Yes No **Signature:** \_\_\_\_\_

**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 **Signature:** \_\_\_\_\_

**Health Care Provider Release** I grant the school nurse permission to exchange information with my child’s health care provider. I understand that I can limit or revoke this consent at any time. Yes No **Signature:** \_\_\_\_\_

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

Yes No **Signature:** \_\_\_\_\_

**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 participate 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 **Signature:** \_\_\_\_\_