

MELROSE SCHOOLS

Confidential Student Health and Emergency Information Sheet

Student's Name: _____ Teacher/Grade: _____

Address: _____

Date of Birth: _____ Sex: Male/Female Primary Language: _____
Resides with: _____ Home Telephone #: _____

Mother's Name: _____ Father's Name: _____

Mother's Home Telephone #: _____ Father's Home Telephone #: _____
Mother's Work Telephone #: _____ Father's Work Telephone #: _____
Mother's Cell Phone #: _____ Father's Cell Phone #: _____

Does your child have health insurance? Y N (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 healthcare (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 #: _____

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

Name: _____ Relationship: _____ Tel. #: _____
Name: _____ Relationship: _____ Tel. #: _____

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 facility if necessary.

Physician's Name: _____ Telephone #: _____

Dentist's Name: _____ Telephone #: _____

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

List all the medications your child takes: _____

I give the school nurse permission to administer the following when appropriate (circle the meds that you agree with): Acetaminophen (Tylenol), Diphenhydramine Hydrochloride (Benadryl) for insect bites/stings, Ibuprofen (grades 6-8) only, Cough drops (Grades 5-8)

Please circle all of the following that apply to your child:

Heart condition Diabetes Asthma Seizure Disorder ADHD/ADD

Migraines Depression Kidney disease Frequent ear infections 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: _____