

Medway Public Schools
Medway, MA
STUDENT HEALTH & EMERGENCY INFORMATION
PLEASE COMPLETE BOTH SIDES OF FORM

Please print:

Grade: _____ Room # _____

Name: _____
(Last) (First) (Middle)

Home Address: _____ Male Female

Mother/Guardian: _____ **Address:** _____

- Home Phone: _____
- Work Phone: _____
- Cell Phone: _____

Please check above the **primary contact number** during school hours.

Primary email address: _____

Father/Guardian: _____ **Address:** _____

- Home Phone: _____
- Work Phone: _____
- Cell Phone: _____

Please check above the **primary contact number** during school hours.

Primary email address: _____

Who has legal custody of this student?

- Both Parents Mother Father Guardian Other

If **Other**, please list name/relationship: _____

Names of local contacts who will assume responsibility/transportation:

Name: _____ Address: _____

Relationship: _____ Phone: _____

Name: _____ Address: _____

Relationship: _____ Phone: _____

In case of emergency, the school will attempt to contact parent/guardian before your child is transported by ambulance to an emergency care facility if necessary.

Physician's Name _____ Telephone _____

Dentist's Name _____ Telephone _____

(OVER)

HEALTH RECORD and FIELD TRIP Use

Grade _____

Room # _____

Name _____ D.O.B.: _____
(Last) (First) (Middle)

Does your child have health insurance? Yes No

Health Insurance Co. _____ Policy # _____

If you have no health insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable health care (restrictions may apply). Please contact the School Nurse for more information about these programs. All communications will be confidential.

Please check all that applies to your child.

Place an asterisk "*" next to condition that is new or has changed from the previous school year.

Allergies (food, insect, medications, environment – *please specify*):

- Asthma Frequent Headaches Seizure Disorder ADD OCD
- Diabetes Migraines Heart Condition ADHD Depression

Please specify problems with:

- Hearing Right Left Hearing Aids
- Vision Right Left Glasses Contacts
- Bone or Joint: _____
- Dental: _____
- Other _____

Does your child have any physical limitations? No Yes

If **YES**, please specify: _____

I wish to speak with the school nurse personally. No Yes

Please list **medications*** your child takes:

***ONLY** medications with written physician **AND** parental permission **ON FILE** with the School Nurse will be allowed **in school or on field trips**. **This includes over the counter medications.** Orders **must be renewed every school year**. See School Nurse for the form.

Does your child need medication(s) on a **FIELD TRIP**? No Yes

If **YES**, list medication _____

I give permission to the school nurse to share information relevant to my child's health condition with appropriate 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.

Parent/Guardian Signature: _____ Date: _____