Medway Public Schools
Medway, MA

STUDENT HEALTH & EMERGENCY INFORMATION

Please print:

Grade: ____________ *Room #* _______________

Name: ____
(Last) (First) (Middle)

Home Address: ____ ☐ Male ☐ Female

Guardian #1: ________________________________ Relationship: ______________________________

Address: ____

☐ Home Phone: ____

☐ Work Phone: ____

☐ Cell Phone: ____

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

Primary email address: ____

Guardian #2: ________________________________ Relationship: ______________________________

☐ 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?

☐ Guardian #1 ☐ Guardian #2 ☐ Both Guardians ☐ Other

If Other, please list name/relationship: _______________________ _________________________
(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**. ***<u>This includes over the counter medications.</u> Orders ***<u>must</u>*** **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: ____________________