

Medway Public Schools  
Medway, MA

**STUDENT HEALTH & EMERGENCY INFORMATION**

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