



**STUDENT HEALTH AND EMERGENCY INFORMATION FORM**

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ Telephone Number \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Primary Language \_\_\_\_\_ Family member serving in the Military \_\_\_\_\_

Name / Age of Siblings \_\_\_\_\_

Mother /Guardian \_\_\_\_\_ Address \_\_\_\_\_ (If different from above)

Phone number \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father/Guardian \_\_\_\_\_ Address \_\_\_\_\_ (If different from above)

Phone Number \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Name of others who will be responsible for your child:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

Physicians Name \_\_\_\_\_ Phone \_\_\_\_\_

Dentist Name \_\_\_\_\_ Phone \_\_\_\_\_

\*Does your child have health insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

**If your child does not have 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 communication will remain confidential.**

**Please list any medical conditions your child has \_\_\_\_\_**

\_\_\_\_\_

**Please list all medications your child takes \_\_\_\_\_**

\_\_\_\_\_

**In case of emergency, the school will attempt to contact a parent/guardian before calling 911. Your child will be transported to an emergency care facility if needed.**

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

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_