# HEALTH & EMERGENCY FORM FOR NURSE 2025-2026

***Please complete ALL requested info and return to school nurse within 2 days***

**Student's Name** _____ **Grade** _____
**Last** **First** **M.I.**

**Address** _____
**Street** **City** **Zip Code**

**Date of Birth** _____ **Home Phone** _____ **Primary Language**_____ **Ethnicity**_____

**Mother's Name** _____ **Email** _____

**Place of employment** _____ **Work phone** _____ **Cell phone** _____

**Father's Name** _____ **Email** _____

**Place of employment** _____ **Work phone** _____ **Cell phone** _____

**Name of parent(s)/guardian with whom student resides** _____

**Persons who have agreed to care for and/or transport your child when parent or guardian cannot be reached. Name of siblings should be included if they will be providing transportation.**

**Name** _____ **Relationship to child** _____ **Phone** _____

**Name** _____ **Relationship to child** _____ **Phone** _____

**Doctor's name** _____ **Phone** _____

**Dentist's name** _____ **Phone** _____

**Does your child have: <u>Health insurance?</u> YES NO (please circle one) <u>Dental insurance?</u> YES NO**

**Health Insurance Company** _____ **Policy Number** _____

***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. ALL communications will be confidential.***

**To better serve your child's medical/physical/emotional/educational/social needs, please check all that pertain to your child:**

**___Heart Condition ___Diabetes ___Asthma ___Seizure Disorder ___ADD/ADHD ___Migraines ___Depression**

**___Other, please specify:** _____

**Allergies (food, insects, medications, environment) Be specific:** _____

_____

**Does your child have hearing problems: ___Yes ___No If yes, ___Left ear ___Right ear ___Hearing Aids**

**Does your child have vision problems: ___Yes ___No If yes, ___Wears glasses ___Contact lenses**

**Please list ALL medications that your child takes:** _____

***<u>No medications will be given (including Tylenol, Advil, cough drops etc.) until a written order is received by the school nurse from a licensed physician and a signed parental consent form is completed. Students should not carry any type of medication, including Tylenol, Advil, cough drops etc.</u>***

**In the event of an emergency situation, I authorize the school to obtain medical/emergency treatment for my child. I understand I will be notified of the emergency as soon as possible.**

**I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs.**

**Parent Signature:** _____ **Date:** _____