Complete Both Sides

Swampscott Public Schools
Emergency/Medical Form

School Year 2018/2019

School:_____ Home Room: _____ Grade: _____

General Information

Student: _____Birth Date: _____ Birthplace:_____
Last First Middle

Address:_____ Home Phone #:_____
Street Address Apt# City State/ Zip Code

Male ☐ Female ☐Language spoken at home: _____

Parent/Guardian

Name: _____
Last First Relationship

Home Phone #: _____
Work Phone #: _____
Cell Phone #: _____
Email Address: _____
Address if different from student:

_____

Parent/Guardian

Name: _____
Last First Relationship

Home Phone #: _____
Work Phone #: _____
Cell Phone #: _____
Email Address: _____
Address if different from student:

_____

Student Sibling(s)

Name: _____ School :_____ Name: _____School:_____

Name: _____ School :_____ Name: _____School:_____

IF YOU ARE UNAVAILABLE: Emergency Contacts /Permission to Dismiss (must be 18 or over)

Name: _____ Relationship: _____ Daytime phone#:_____

Name: _____ Relationship: _____ Daytime phone#:_____

Name: _____ Relationship: _____ Daytime phone#:_____

Name: _____ Relationship: _____ Daytime phone#:_____

My Child May Not Be Dismissed To:

*Valid Restraining Order

Name: _____ Relationship: _____ ☐ Yes ☐ No

Name: _____ Relationship: _____ ☐ Yes ☐ No

(If yes, you must attach copy of order)

*****Parent /Guardian Signature:_____**

**** PLEASE TURN OVER AND COMPLETE OTHER SIDE ****

Complete Both Sides

STUDENT NAME:_____

HEALTH HISTORY

Do you have medical insurance?
□ Private □ Public (E.g., MA Health, Children's Medical Security) □ No insurance
Name of Insurance Provider: _____ Group/Policy #: _____
(Please contact the school nurse if you need assistance applying for medical insurance)

Medical Information

Please **CHECK ALL BOXES** that apply to your child. Contact the school nurse for additional confidential medical information.

ALLERGIES (food, insects, medications, environment) _____ **Epi-Pen? □ YES □ NO**

□ **Asthma** □ **ADD/ADHD** □ **Autism** □ **Bleeding/clotting problems** □ **Depression**

□ **Diabetes** □ **type I** □ **type II** □ **Heart defect/disease** □ **Kidney Disease**

OTHER_____

□ **History of concussion with date(s) _____**

□ **Convulsions/seizures (date of last seizure):_____ Type of seizure disorder**:_____

□ **Operations or serious injuries** (dates)_____

□ **Special medical equipment** required _____

□ **Vision Problems** (specify) _____ Wears eyeglasses**?** □ **YES** □ **NO** Wears contacts? □ **YES** □ **NO**

□ **Hearing Problems** (specify)_____ □ Left ear □ Right ear Hearing aid **? ?** □ **YES** □ **NO**

Date of last physical exam: _____Restrictions (doctor's note required):_____
(Copy/proof of physical required prior to school entry and in grades K, 4, 7 and 10. Please send to school nurse.)

Medication(s) your child is currently receiving:

At home: _____

At school:_____

Student's Doctor/Pediatrician	**Dental Care Provider**
Name Phone Number	Name Phone Number

DO NOT LEAVE BLANK: PARENT AUTHORIZATION

□ **YES** □ **NO** 1. 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.

□ **YES** □ **NO** 2. I give permission to the school nurse to exchange information with my child's health care providers for the purpose of referral, diagnosis and treatment.

□ **YES** □ **NO** 3. I give permission for the school nurse to administer **Acetaminophen** to my child.

□ **YES** □ **NO** 4. I give permission for the school nurse to administer **Ibuprofen** to my child.

□ **YES** □ **NO** 5. I give permission for the school nurse to apply **Calcium Antacid** to my child.

□ **YES** □ **NO** 6. I give permission for my child to be transported to the hospital and receive medical attention in the event that I cannot be reached in an emergency

□ **YES** □ **NO** 7. This health history is correct as far as I know, and my child has permission to participate in all activities except as noted by me.

***Parent/Guardian's Signature _____Date _____