School Health Information
Holliston, Massachusetts

Name____Grade____________
Last First Middle
Birthdate___/___/___Birthplace___________________________Gender: Male_____Female_____

Home Address____
Email Address____
Parent/Guardian_____________________________________Home Tel#______________________
Work/Cell______________________
Second Parent______________________________________Home Tel#______________________
Address____Work/Cell______________________
If different from above

Is your child covered by family medical/hospital insurance? Yes____ No___
If so, indicate carrier or plan name_______________________ ID # ________________________
If you have no health insurance, Massachusetts has health insurance plans that will provide for 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.

Name of child's physician______________________________Telephone_____________________
Address____

Name of child's dentist/orthodontist_______________________Telephone____________________

<u>Please check all that apply</u>:

____**Allergies** List all known & describe reaction and management of reaction.
- __Food____
- __Environmental____
- __Medication____
- __Other____

___ADHD/ADD
___Arthritis
___Asthma
___Autism Spectrum Disorder
___Blood Disorder
___Cancer
___Cardiac Condition
___Depression

___Diabetes Type l
___Diabetes Type ll
___Eating Disorder
___Learning Disability
___Migraines
___Pervasive Development Disorder
___Seizure Disorder

___Other Physical Conditions
Explain:______________________
____
___Other Behavioral/Emotional Conditions. **Explain**___________
____

- **___Vision (Explain)**____
- **___Hearing (Explain)**____
- **___Speech/Language (Explain)**_______________________________
- **___Preferential Seating (Doctors note required)**
- **___IHP (Individual Health Plan)**
- **___IEP (Individual Education Plan)**
- **___504 Plan**

Continued on other side

Permission to administer medication (Tylenol, Ibuprofen, Tums)

___ **YES** my child may be administered Tylenol or Ibuprofen by the school nurse.
___ **NO** my child may not be administered Tylenol or Ibuprofen by the school nurse.

___ **YES** ___ **NO** my child may be administered an antacid (Tums) by the school nurse.

Medications Being Taken

Please list all medications (including over- the-counter or non prescription drugs) taken routinely.

___This child takes **NO** medication on a routine basis.
___This child takes medication as follows:

Medication #1________________Dosage____________Times taken_________Reason____________

Medication #2________________Dosage____________Times taken_________Reason____________

Medication #3________________Dosage____________Times taken_________Reason____________

Limitations or Restrictions

List and explain any restrictions:

Dietary____

Activity____

Other____

Please provide any additional information about your child's behavior and physical, emotional and mental health about which the nurse/guidance counselor should be aware of.

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____

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. I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis and treatment.

In case of emergency or clarification of medication, the school will attempt to contact parent/guardian before calling the student's primary care provider (physician). Your student will be transported by ambulance to an emergency care facility if necessary.

Parent/Guardian Signature____ **Date**____________

*Parent/Guardian signature is required for any Tylenol / Ibuprofen/ antacid to be administered.

Please return this form to your child's school nurse