

Student I.D.# _____

Home Room _____

EMERGENCY INFORMATION

Please complete the information requested below and return to school immediately. Contact school nurse if assistance is needed to complete form.

Student's Name _____ Grade _____ Date of Birth _____ Place of Birth _____

Address _____ Telephone _____

Language of Home _____ Policy Number _____

*Email _____

Does your child have Health Insurance? Yes No Health Insurance Co. _____

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.

Names of (Custodial) Parents/Guardians _____

Please provide us with all the numbers to reach you during the day. Please prioritize them and identify the location.

Call first: _____ Mom at Work _____

Call second: _____ Mom's cell _____

Call third: _____ Dad at work _____

Call fourth: _____ Dad's cell phone _____

Address _____ Email* _____ Telephone _____

Other Children _____ Grade _____
_____ Grade _____
_____ Grade _____

If I cannot be reached, the following local people have agreed to assist me, if necessary.

Name _____ Telephone _____
Address _____ Relationship _____
Name _____ Telephone _____
Address _____ Relationship _____
Name _____ Telephone _____
Address _____ Relationship _____

In case of emergency, the school will attempt to contact parent/guardian before calling student's primary care provider (physician). Your child will be transported by ambulance to an emergency care facility if necessary. If your child has an allergy, asthma, or any health concerns, please explain here, or call the school nurse. When medication of any kind (prescription or over the counter) needs to be dispensed during the school day, it must be sent in its "original" container, with written permission from parent or guardian. If your child needs to carry an inhaler or epi-pen, please contact the school nurse immediately. Confidentiality is respected regarding this information.

Physician Name _____ Phone _____

Please list all medications that your child takes.

Please check all that applies to your child:
 Heart Condition Diabetes Asthma Seizure Disorder ADD/ADHD Migraines Depression
 Allergies (food, insects, medication, environment) (Specify) _____

(Non-custodial parent) _____
Restriction to Access (to records, child, dismissal, restraining order etc.) _____

Verifying Documentation _____ Date _____

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.

I give my consent for the school to seek nearby medical care in an emergency.

Parent/Guardian Signature Date

*Email address where detailed information may be sent.