2025-2026

STUDENT HEALTH AND EMERGENCY INFORMATION FORM
FILL OUT IN BLACK OR BLUE PEN ONLY

Student name _____ Grade_____
Last First Middle (full middle name)

Address_____
No. Street Town Zip code

Home Phone_____Gender_____Date of Birth_____

Language(s) spoken at home_____ Place of Birth_____ Does child have

health insurance? Circle Yes/No Name of Insurance Company_____

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 communication is confidential.

Please circle one number that can be reached at all times.

Parent 1/Guardian Name (printed)_____

Home Address_____

Home Phone_____ Work Phone_____

Cell Phone_____Email_____

Signature_____

Parent 2/Guardian Name (printed)_____

Home Address_____

Home Phone_____ Work Phone_____ Cell

Phone_____Email_____

Signature_____

IN CASE OF EMERGENCY AND NEITHER PARENT CAN BE REACHED,
PLEASE LIST NAME AND PHONE NUMBER OF RELATIVE OR FRIEND WE MAY CONTACT.

EMERGENCY NAME_____Relationship_____
Home Phone_____Work Phone_____Cell Phone_____
Physician's Name_____Phone_____
Dentist's Name_____Phone_____
Hospital of Choice_____(EMT or Paramedic may override choice)

Please check all that apply to your child:
Heart condition_____ Diabetes_____ Asthma_____ Seizure Disorder_____ADD/ADHD_____Migraines_____Depression_____
Medications/Other_____

Allergies (food, insects, medication, environment (specify)_____
Does your child have an EpiPen? Yes_____ No_____
Hearing Problems (specify) right ear_____left ear
Vision Problems (specify) _____
I give my permission for the school nurse to administer Acetaminophen/Ibuprofen to my child_____yes _____no 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 physician/counselor for the purpose of referral, diagnosis and treatment_____yes_____no

Parent/Guardian signature_____Date_____

I give the school nurse permission to email me at the above addresses with nonurgent medical issues*

Please initial: _____yes _____no