Malden Public Schools - Student Health Information 2026/2027 HR _____

Student's Last Name_____ First Name_____ DOB _____ Gender_____

Address_____ Is English spoken at home _____ If no, _____

Name(s) Parent/Guardian #1_____ **#2**_____

Parent/Guardian #1 Cellphone_____Work # _____ **#2** Cellphone_____Work # _____

In case of an emergency or illness and we are unable to reach the contacts listed above, please provide 2 alternative contacts who will assume responsibility and transportation:

1. Name _____Relationship_____ Phone_____

2. Name _____Relationship_____ Phone_____

Please indicate if your student has any of the following health conditions:

Anxiety/Depression	YES	NO	Daily Medication	YES	NO	Orthopedic/Joint issues	YES	NO
ADD/ADHD	YES	NO	Diabetes	YES	NO	Seasonal Allergies	YES	NO
Asthma/Eczema	YES	NO	Eating Disorder	YES	NO	Seizures	YES	NO
Bathroom/Toileting	YES	NO	Hearing Problems	YES	NO	Speech Problems	YES	NO
Blood Disorder	YES	NO	Heart Condition	YES	NO	Tuberculosis	YES	NO
Concussion	YES	NO	Headaches	YES	NO	Vision Problems	YES	NO
Allergy to Food	YES	NO	Allergy to Medicine	YES	NO	EpiPEN	YES	NO
Any Surgeries	YES	NO	Accidents/Injuries	YES	NO	Other (list below)	YES	NO

If you answered YES, please explain: _____

_____

_____**ALLERGY TO**:_____

****DO NOT LEAVE BLANK****

PARENT/GUARDIAN AUTHORIZATION (Written Consent is required before any medication is given to your student)

YES NO 1. I give permission for the school nurse to administer **TYLENOL/ACETAMINOPHEN** to my student.
YES NO 2. I give permission for the school nurse to administer **IBUPROFEN/MOTRIN/ADVIL** to my student
YES NO 3. I give permission for the school nurse to administer **TUMS** (antacid tablets) to my student
Yes NO 4. I give permission for the school nurse to administer **BENADRYL/DIPHENHYDRAMINE HCL** (***only given for allergic reactions)*** to my student

Medication dosage will be determined by student's weight and age

I give permission for the school nurse to share information relevant to my student's health with appropriate school personnel when needed to meet their health and safety needs. I give permission to exchange information with their primary physician for the purpose of referral and diagnosis and treatment. please circle: YES NO

PARENT/GUARDIAN SIGNATURE_____**DATE**_____

For office use only: Nurse review _____ (2026/2027)