Melrose Public Schools
Confidential Student Health and Emergency Information Sheet

Student's Name _____ Teacher _____Grade _____
Date of Birth _____ Sex: Male _____ Female _____ Non-binary _____
Primary Language _____
Address _____
Resides with _____ Home Telephone _____
Name(s) Parent/Guardian #1 _____ #2 _____
Parent/Guardian #1 Work Phone _____ #2 _____
Parent/Guardian #1 Cell Phone _____ #2 _____
E-Mail #1 _____ #2 _____
Names and grades of siblings in Melrose Schools:_____
Does your child attend a before or after school program or have a sitter (Y / N) If yes, please provide the contact name and telephone number: _____

Does your child have health insurance? Please circle Yes / No Private / Public*_____
*If you don't have health insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable healthcare (restrictions may apply). Please contact your school nurse for more information about these programs. All communications are confidential.
Note: In case of an emergency and 911 is called, your child will be transported by ambulance to an emergency care facility, if necessary. Please indicate your hospital preference:_____

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

Pediatrician _____ Phone _____
Dentist _____ Phone _____
How often does your child visit the dentist? Please circle: Once a year Twice a year Never

List ALL medications your child takes: _____
_____

I give the school nurse permission to administer the following (please circle the medications that you agree with):
Acetaminophen (Tylenol) Diphenhydramine Hcl (Benadryl) Ibuprofen (Advil) –grades 6-12 only Tums

Please circle all the following that apply to your child: History of Concussion Yes /No How many? _____

Heart Condition Diabetes Asthma Seizure Disorder Migraines ADHD / ADD Rheumatic Fever

Depression Kidney Disease Frequent Ear Infections Other _____

Speech Problems (specify) _____
Hearing Problems (specify) _____
Vision Problems (specify) _____
Allergies (specify-food, environmental, medication, insect) _____

I give permission to the school nurse to share this 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.

Signature of Parent/Guardian _____ Date _____