Emergency Contact Information

☑ **Annual Update**

*Double-sided | Billerica Public Schools | School Year: 26-27

Child's First Name:	**Child's Middle Name:**	**Child's Last Name:**			**School: Marshall Middle School**	
Street Address:		**City:**	**State:**	**Zip Code:**	**Grade:**	
Date of Birth: (MM/DD/YYYY)	**Gender:**	**Hair Color:**			**Teacher & Team:**	
Height: Ft. in.	**Weight:**	**Eye Color:**			**Bus #:**	**Homeroom:**

Are there any custodial concerns regarding this child? **YES _____ NO _____

In order to comply, the proper legal documentation must be received by the appropriate school office.

Please indicate where parent/guardian can be reached during the day:		**Persons to contact if parent/guardian cannot be reached:**	
Parent/Guardian 1st to call	**Parent/Guardian 2nd to call**	**Contact 1**	**Contact 2**
Name:	**Name:**	**Name:**	**Name:**
Relationship:	**Relationship:**	**Relationship:**	**Relationship:**
Home Phone:	**Home Phone:**	**Contact Phone:**	**Contact Phone:**
Work Phone:	**Work Phone:**	**Child refers to as:**	**Child refers to as:**
Mobile Phone:	**Mobile Phone:**	**Mobile Phone:**	**Mobile Phone:**
Email:	**Email:**	**Email:**	**Email:**

SIBLING INFORMATION (If applicable):	**School**	**Grade**
Name:		
Name:		
Name:		

MEDICAL INSURANCE INFORMATION:				
Subscriber:	**Group #:**	**Policy #:**	**Insurance Company:**	**Physician:** **Phone:**
DENTAL INSURANCE INFORMATION:				
Subscriber:	**Group #:**	**Policy #:**	**Insurance Company:**	**Dentist:** **Phone:**

EMERGENCY PERMISSION: In the event I can't be reached in an emergency, I give permission to school authorities to provide emergency medical treatment in the case of injury or illness for my child as considered necessary. I accept responsibility for any expenses incurred in handling emergency care.

Parent/Guardian Signature: _____ ***Date:*** _____

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Medical Information

Please Print:				
Student's Name:	Grade:	Teacher:	Homeroom:	Preferred Hospital:

Does your child have any **LIFE THREATENING FOOD ALLERGIES**? Yes ☐ No ☐ Does your child require the use of an **EPI-PEN**? Yes ☐ No ☐ Does your child have **LATEX ALLERGIES**? Yes ☐ No ☐

Does your child have a **LIFE THREATENING NON-FOOD ALLERGY**? Yes ☐ NO ☐ Does your child have **SEASONAL ALLERGIES**? Yes ☐ No ☐

Is an **INHALER** or **NEBULIZER** prescribed for your child? Yes ☐ No ☐ Will it be sent to school? Yes ☐ No ☐ Does your child have **ALLERGIES TO MEDICATIONS**? Yes ☐ No ☐

If "yes" above, please describe:_____

Please check all conditions that apply:			
☐ ADD/ADHD	☐ Developmental Delays	☐ Kidney	Hospitalization this year? Yes ☐ No ☐ Reason:
☐ Anxiety	☐ Ear Infections	☐ Lactose Intolerant	
☐ Arthritis	☐ Epilepsy (seizures)	☐ Migraines	Previous concussions? Yes ☐ No ☐ Dates:
☐ Asthma	☐ Eczema	☐ Nosebleeds	
☐ Autism Spectrum	☐ Eyeglasses/Contacts	☐ Reflux (other)	Other medical conditions? Yes ☐ No ☐ Explain:
☐ Bladder/Bowel Control Issues	☐ Gastric Reflux	☐ Scoliosis	
☐ Constipation	☐ Hearing Loss	☐ Strep Throat (history of)	
☐ Celiac	☐ Heart Condition	☐ Ulcers	
☐ Diabetes	☐ Hepatitis	☐ Other:	

All Students can receive the following:

I give permission for the school nurse to administer and/or apply the following medications approved by our school physician: Anti-itch cream, First Aid Cream, Oral pain reliever, Saline Eye wash, Antibiotic ointment, Hydrogen Peroxide, Acetaminophen (Tylenol), Diphenhydramine (Benadryl) or Vaseline. Yes ☐ No ☐

I understand that the school nurse is permitted to share medical information with authorized school personnel. Yes ☐ No ☐

I give the school nurse permission to speak and exchange information with my listed pediatrician to facilitate care of my child. Yes ☐ No ☐

Middle and High School Students Only: In addition to the above, I give permission for the School Nurse to administer ibuprofen, chewable antacid tablets. Yes ☐ No ☐

****Any medications to be given during the school day, must be submitted to the School Nurse offices with: 1.) written physician's order 2.) written parental permission, and 3.) be supplied and delivered by an adult in the original labeled container.**

Please list any other medical, mental or physical, health concerns/issues and/or past medical problem that limits activity at school or can help the School Nurse care for your child:

Parent/Guardian Signature: _____ ***Date:*** _____