MELROSE PUBLIC SCHOOLS
CONFIDENTIAL STUDENT HEALTH AND EMERGENCY INFORMATION

Student's Name: ____ Grade: ____________________
Last/First/Middle

Address: ____

Date of Birth: ____________________ Sex: Male/Female Primary Language: ____________________

Resides With: __________________________________ Home Telephone: ____________________

Parent/Guardian 1: ______________________ Parent/Guardian 2: ________________________

Home Telephone: ______________________ Home Telephone: ________________________

Work Telephone: ______________________ Work Telephone: ________________________

Cell Phone: ______________________ Cell Phone: ________________________

Does your child have health insurance? Y N (circle one)

Health Insurance Company ______________________________ Policy # ____________________

> If you don't have health insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable health care (restrictions may apply). Please contact your school nurse for more information about these programs. All communications are confidential.

Name and grade 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: ____

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

Name: ________________________ Relationship: ____________________ Telephone: ______________

Name: ________________________ Relationship: ____________________ Telephone: ______________

*** In case of an emergency, we will attempt to contact the parent/guardian before calling the student's primary care provider (physician). Your child will be transported by ambulance to an emergency care facility, if necessary.*

Physician's Name: __________________________________ Telephone Number: ____________________

Dentist's Name: __________________________________ Telephone Number: ____________________

How often does your child visit the dentist? ____ once a year ____ twice a year ___ has never been to a dentist

List all medications that your child takes: ____

I give the school nurse permission to administer the following when appropriate (circle the meds that you agree with): Acetaminophen (Tylenol) / Diphenhydramine Hydrochloride (Benadryl) (insect bites/stings) / Ibuprofen (grade 6-12 only) / Cough Drops (grades 5 & over)

Please circle all the following that apply to your child:

Heart Condition Diabetes Asthma Seizure Disorder ADHD/ADD

Migraines Depression Freq. Ear Infections Kidney Disease Rheumatic Fever

Speech Problems (specify) ____

Hearing Problems (specify) ____

Vision Problems (specify) ____

Allergies (specify – food, environment, medication, insect) ______________________________

Other (specify) ____

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:** ____________________