MEDICAL AND SPECIAL NEEDS INFORMATION FORM — EDUCATION STATIONS

Last Name:	First Name:	
DOB:	School:	Entering Grade:

Does your child currently have any chronic health conditions?

- ☐ No, my child does not currently have any chronic health conditions. I will give notice if this status changes.
- ☐ Yes, my child has chronic health conditions. I will provide information as required below.

If yes, list chronic health conditions (asthma, allergies, other medical/psychological diagnoses), health concerns, medications and/or special dietary requirements. Please explain severity/related needs in detail.

Parents of students who may require medication during programming must complete page 2 of this document, the Medication Administration Consent. A current prescription and doctor's orders of necessary medications must be provided for after school storage and use.

Pediatrician/Family Doctor's name:	Phone number(s) and contact information/instructions:

Does your child demonstrate any emotional/behavioral difficulties?

- ☐ No, my child does not currently demonstrate any emotional/behavioral difficulties
- ☐ Yes, my child demonstrates emotional/behavioral difficulties, which I will further explain below.

If Yes, please explain below how our staff may assist your child.

Do you give permission to Education Stations Program Coordinator to communicate with school day staff regarding the best way to support your child?

- ☐ Yes
- ☐ No

By signing below you agree to abide by the policies and procedures set out in the handbook and included in this Parent Permission packet. An electronic version is available at www.melroseschools.com

Name_____ SIGNATURE_____ Date_____

REQUIRED FORM FOR ALL EDUCATION STATIONS STUDENTS

Melrose Public Schools —Education Stations
Education Stations Administrative Offices, 360 Lynn Fells Parkway
Melrose, MA 02176 (781) 462-3266

WRITTEN PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

Name of Student: _____ Date of Birth: _____

Name of Parent/Guardian: _____ Home Phone: _____

Address: _____

Alternate Phone Numbers: _____

Allergies: _____

_____

I will be providing the after school program with the following medications for my child: _____

_____

Other medications taken by your child on a regular basis: _____

- ❑ I give permission for a trained staff member to administer the following:

Name of Medicine: _____ Dosage: _____ Time(s): _____

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Name of Medicine: _____ Dosage: _____ Time(s): _____

Please check boxes below if you give permission for the following:

- ❑ I give permission for my son/daughter to self-administer medication if a trained staff member determines it is safe and appropriate.
- ❑ I give permission for a trained staff member to share with appropriate personnel information relative to the prescribed medicine administration (e.g. adverse side effects) as s/he determines necessary for my son/daughter's health and safety

- ❑ **Any restrictions on release?**

Please note: <u>A current prescription and doctor's orders of the above medication(s) must be provided for after school storage and use</u>. I understand that I may retrieve the medicine from the school at any time and that the medicine will be destroyed if it is not picked up by end of school day at end of school year .

Signature(s) of Parent(s) or Guardian(s)_____

Date:_____

***<u>REQUIRED FORM ONLY FOR CHILDREN WITH MEDICATION*</u>**

FOR OFFICE USE ONLY:
Student ID: _____
MCC: □
Rosters: □

EDUCATION STATIONS – EMERGENCY CONTACT INFORMATION

Melrose Public Schools
Education Stations Administrative Offices, 360 Lynn Fells Parkway
Melrose, MA 02176 (781) 462-3266

School: _____ Grade: _____

Student's Last Name: _____First Name: _____Middle:_____

Home Address: _____ Telephone Number:_____

Parent/Guardian Name: _____

Parent/Guardian Home Address: _____

Parent/Guardian Cell Number: _____

IN CASE OF EMERGENCY CALL•

1. _____
   Name Tel. No. Relationship

2. _____
   Name Tel. No. Relationship

3. _____
   Name Tel. No. Relationship

Family Health Insurance Plan: _____

Policy Number: _____

PRINTED NAME of Parent(s) or Guardian(s)_____

Signature(s) of Parent(s) or Guardian(s) _____

Date: _____

REQUIRED FORM FOR ALL EDUCATION STATIONS ELEMENTARY STUDENTS