Haverhill Student Health and Emergency Information Form

Complete the following information and return to school immediately. Contact school nurse if assistance is needed to complete form.

Student's Name: _____
(Last Name) (First Name) (Full Middle Name) (Grade) (Homeroom)

Address_____

Sex_____ D.O.B._____ Place of Birth_____ Primary Language_____

Mother/Guardian/Other _____ Address_____

Phone: Home_____Cell_____ Work_____

Father/Guardian/Other_____Address_____

Phone: Home_____ Cell_____ Work_____

Name & Grade of sisters/brothers in school system_____

Name of others who will assume responsibility/transportation

Name_____Relationship_____ Phone_____

Name_____Relationship_____Phone_____

Does your child have health insurance? Yes___ No ___ Does your child have Dental Insurance? Yes ___ No ___

Health Insurance Company_____ Dental Insurance Company_____

List all the Name of Medication your child takes The Dose How often and why they are taking this medication

_____

_____

_____

_____

_____

In case of Emergency, the school will attempt to contact parent/guardian. In the event that we are unable to contact you, your child will be transported by Ambulance to the nearest hospital accompanied by a responsible adult.

Physician Name_____ Phone Number (_____)_____

Dentist Name_____Phone Number (_____)_____

Please check all that apply to your child

☐ Heart Condition ☐ Diabetes ☐ Asthma ☐ Seizure Disorder ☐ ADD/ADHD ☐ Migraines ☐ Depression

☐ Other (Specify) _____

☐ Hospitalization/Surgeries (Specify) _____

☐ Allergies (food, insects, medication, environment)(Specify)_____

☐ Hearing Problems (Specify) Left ear_____ Right ear_____ Hearing Aids_____

☐Vision Problems (Specify) Wears Eyeglasses _____Contact Lenses _____Preferential Seating_____

☐ Dental Problems_____☐ Postural (back Problems)_____ ☐ Physical Limitations (Specify)_____

I give the School Nurse Permission to administer the following <u>Over the Counter Medication</u> in accordance with the established protocols. Tums will be administered to students age 11 and over.

☐ **Ibuprofen/ Advil/Motrin**

☐ **Tylenol/Acetaminophen**

☐ **Oragel**

☐ **Tums**

I give permission to the School Nurse to share information relevant to my child's health condition and medication with appropriate school personnel needed to meet my child's health and safety needs.

Signature _____ Date_____