Nashoba Regional High School

School Health Services: Student Emergency and Health Record

School Year 2016-2017

Return to School Nurse
Grade:_____ Bus ____
Homeroom: _____

Student Name _____ **Date of Birth** _____ **Birth city**_____

Address _____ **Town** _____ **Zip**_____ **Gender:** _____

Mother/Guardian _____ **Employer** _____

Father/Guardian _____ **Employer** _____

Parent/Guardian Email _____

SIBLINGS

Name					
Age					
School					

TELEPHONE NUMBERS: Include extensions and other prompts

	Home	Cell	Work/Daytime Phone	Preferred Phone
Student		N/A	N/A	N/A
Mother/Guardian 1				
Father/Guardian 2				

With whom does the child reside? _____

Request Second Guardian Mailing Yes or No (circle one) If yes provide address below.

_____

EMERGENCY CONTACTS: LOCAL persons to be notified in case of an emergency or illness, **when you are unable to be reached. Your child will only be released to the care of those listed below.**

Name	Relationship	Phone	Type of Phone	Other
	Daycare Provider			

PERMISSIONS - Please read and make selection

PTO Release: I hereby give my permission for Nashoba Regional School District to release the following Parent/Guardian information to the PTO for their published directory: child name, parent name, address, email, and phone number.
Accept_____ **Decline**_____(Please check one)

PHOTOGRAPHS: You may include and photograph my child. **Accept**_____ **Decline**_____ (Please check one)

CONFIDENTIAL INFORMATION: The school nurse may share health information about your child, on a need to know basis, with his/her teachers and coaches unless you request otherwise, in writing.
The school nurse may communicate electronically with you (parents/guardians) regarding your child's health information unless you request otherwise, in writing. Nurse contact informatin is available at www.nrsd.net (District - Health Services) and on school websites.

NOTIFICATION REGARDING STUDENT IDENTIFICATION: Throughout the year, faculty, staff, and the administration attempt to acknowledge and celebrate the achievements, work and contributions of students and community members. We do this through the display of work, verbal recognition, and through various printed, electronic, recorded, and photographic mediums. Also, your son/daughter's name and phone number may be listed in a student directory unless you request not to be listed.

HEALTH INSURANCE: Name of Company _____ **Mass Health** _____ **No Insurance** _____
If you have no health insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable health care (restrictions may apply). Please contact the school nurse for more information about these programs. All communications will be confidential.

MEDICAL RELEASE: I grant to the Nashoba Regional School District personnel, the right to obtain emergency medical treatment for my child, _____, during the period of the school year. I give permission for ambulance transport to the nearest hospital. Payment for any and all medical treatment is the financial responsibility of the parent/guardian.

MILITARY FAMILY STATUS: Is there a Parent/Guardian in the student's household who is currently in the military? Yes or No

Parent/Guardian Signature _____ **Date** _____

Above information is correct and accept all unless indicated_____Please Initial

Please turn page over to complete side 2 of this form.

HEALTH HISTORY: LIFE THREATENING ALLERGIES

Please indicate if your child has a ***physician verified*** allergy to any of the following. If yes, please provide official documentation by your child's physician and an Emergency Care Plan to the school nurse at the beginning of the school year. Written prescriptions are required for all Epi Pens, Benadryl, and inhalers.

Bee Stings _____ **Peanuts** _____ **Nuts** _____ **Medication** _____ **Other** _____

Describe students allergic reaction _____ **Emergency Care Plan** _____

Is Epi Pen required?	Yes No	Is Benadryl required?	Yes No
Has Epi Pen ever been used?	Yes No	Has Benadryl ever been used?	Yes No
Does Student carry his/her own Epi Pen?	Yes No	Athma Inhaler	Yes No

Other Allergies: Please list

Medications _____ Lactose Intolerance _____ Seasonal _____

Environmental _____ Other _____

Describe Reaction _____ Medication used for symptoms _____

DIET: Indicate Dietary Restrictions _____

Illness/Chronic Conditions: Indicate if your child has experienced any of the following and explain below

Anxiety	_____	Asthma	_____	Attention Deficit	_____
Celiac Disease	_____	Concussion	_____	Depression	_____
Diabetes	_____	Fainting	_____	Heart Condition	_____
Hearing Deficit	_____	Hospitalization	_____	Migraines	_____
Recent Surgeries	_____	Injuries	_____	Scoliosis	_____
Seizures	_____	Vision Deficit	_____	Other	_____

Please explain condition _____

HEALTH CARE PROVIDERS:

Physician: _____
Name Street Address Town Zip Telephone

Dentist: _____
Name Street Address Town Zip Telephone

DENTAL: Dental Insurance **Yes No** Do benefits include? Flouride _____ Cleanings _____ Sealants _____

Does your child visit the dentist every six months? **Yes No** Date of last exam _____

VISION: Eyeglasses _____ Contact Lenses _____ Date of Last Eye Exam: _____

SPORTS: Do you know of any reason your child should not participate in sports? Please indicate. _____

***A physical exam is required annually for school sports at the middle and high school level.

MEDICATIONS: Please list prescribed and over the counter medications your child takes. Include herbal treatments.

Name of Medication & Dose	Reason	Home	School

MEDICATION ADMINISTRATION: All prescriptions and Over The Counter (OTC) medications not listed below require a written physician's order. Per NRSD protocol, administration of the OTC medications listed below would not require a physician's order. Communication with the school nurse **is** required to arrange for medication administration and may include the development of a Medication Administration Plan and assessment for authorization of self-administration.

My child has permission to take the following OTC medications or generic substitutions (please check all that apply):

Acetaminaphen(Tylenol)___Ibuprofen(Motrin, Advil)___ Antacid(Tums)___ Benadryl___ *Sunscreen___ *Insect Repellent___

Please notify me each time my child receives any medication. Yes _____ No _____, this is not necessary.
Verbal parental permission will also be obtained prior to medicating students in PreK-5th grade.

Please note: The above OTC medications may be given only once during the school day. Also, the school nurse may use first aid treatments, including topical ones (i.e. bacitracin, hydrocortisone, calamine) to treat allergic rashes, insect bites, toothaches, minor wound infections, and minor burns unless otherwise indicated by parent/guardian. *Please contact your child's school nurse for information on the use of sunscreen and insect repellent at school.

Parent/Guardian Signature _____ **Date** _____