Return to School Nurse
Sept. 2017 Grade:_______

Nashoba Regional High School
School Health Services: Student Emergency and Health Record
School Year 2017-2018

Student Name ______________________ **Date of Birth** ____________ **Birthcity** ____________
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: <u>LOCAL</u> 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**

Please check the appropriate box if YOU DO NOT give Nashoba Regional School District permission to engage in the following activities (please leave blank if you do give permission).

☐ **NRSD may not** release the following Parent/Guardian information to the PTO for their published directory; child name, parent name, address, email, and phone number.

☐ **NRSD may not** release photographs of my child for publication.

☐ **NRSD may not** have the athletic director and/or trainor share health information about my child, on a need to know basis with teachers, coaches, and support staff.

☐ **NRSD may not** release __________ information to the US Military. **Under the No Child Left Behind Act, name, address and phone number of secondary students will be released to the U.S. Military.

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 daughter's name and phone number may be listed in a student directory unless you request not to be listed.

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.

MILITARY FAMILY STATUS: Is there a Parent/Guardian in the student's household who is currently in the military? Yes or No
If yes, please check the one that applies. __ Child of active duty member
__Child of members or veterans who are medically discharged or retired for 1 year
__Child of member who died on active duty

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.

Parent/Guardian Signature ________________________________ **Date** ______________

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 your child's reaction. ________________________________ **Emergency Care Plan** ________________________

Is Epi Pen required? Yes No

Has Epi Pen ever been used? Yes No

Does ___________ carry his/her own Epi Pen? Yes No

Is Benadryl required? Yes No

Has Benadryl ever been used? Yes No

Asthma Inhaler Yes No

Other Allergies: Please list.

Medications ______________________________ Lactose Intolerance_________________________ Seasonal ___________

Environmental ____________________________ Gluten Intolerance ____

Describe Reaction. __________________________ Medication used for symptoms

Indicate treatment for allergic reaction at school. ____

Indicate Dietary Restrictions. ____

Illness/Chronic Conditions: Indicate if your child has experienced any of the following. If yes, please explain condition below.

Anxiety	_________	Asthma	_________	Attention Deficit	_________
Celiac Disease	_________	Concussion	_________	Depression	_________
Diabetes	_________	Fainting	_________	Heart Condition	_________
Hearing Deficit	_________	Migraines	_________	Recent Surgeries	_________
Injuries	_________	Scoliosis	_________	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

<u>MEDICATION ADMINISTRATION</u>: Per NRSD protocol, and with your signature below, our school nurses may dispense the following over-the-counter medications after assessment of your child:

Ibuprofen (Advil, Motrin)____ Acetaminophen (Tylenol) ____ Antacid (Tums)____ Benadryl ____

****To <u>DENY</u> permission for the medications listed above, please check here. _____**

<u>All</u> other medications require a written prescription from your physician and your signed permission.

<u>Please note:</u> 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** __________________