

Nashoba Regional High School
 School Health Services: Student Emergency and Health Record
 School Year 2011/2012

Return to School Nurse
Sept. 2011 Grade: _____

Student Name _____ Date of Birth _____ Birthplace _____
 Address _____ Town _____ Zip _____ Gender: _____
 Mother/Guardian _____ Address _____ Town _____ Zip _____
 Employer _____ Address _____ Town _____ Zip _____
 Father/Guardian _____ Address _____ Town _____ Zip _____
 Employer _____ Address _____ Town _____ Zip _____
 Parent/Guardian Email _____

SIBLINGS

Name					
Age					
School					

TELEPHONE NUMBERS: Include extensions and other prompts

	Home	Work/Daytime Phone	Cell	Other
Mother/Guardian 1				
Father/Guardian 2				

With whom does the child reside? _____ Name & Address, if different _____

Primary Language at Home _____

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	Home/Daytime Phone	Work, if different	Cell

**** 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 WILL be listed in a student directory unless you circle the following:

Do NOT include my child's information or photograph.

****Under the No Child Left Behind Act, name, address and phone number of secondary students will be released to the U.S. Military unless you indicate that you do NOT want your child's information released. Circle DO NOT RELEASE, if applicable.**

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.

CONFIDENTIAL INFORMATION: I grant permission to the school nurse, athletic director, and/or trainer to share health information about my child, on a need to know basis, with his/her teachers, coaches, and support staff. **YES NO**

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 _____

HEALTH HISTORY: LIFE THREATENING ALLERGIES

Please indicate if your child has *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 Is Benadryl required? Yes No
 Has Epi Pen ever been used? Yes No Has Benadryl ever been used? Yes No
 Does _____ carry his/her own Epi Pen? Yes No Asthma Inhaler Yes No

Other Allergies: Please list.
 Medications _____ Lactose Intolerance _____ Seasonal _____

Environmental _____ Other _____

Describe Reaction. _____ Medication used for symptoms _____

Indicate treatment for allergic reaction at school. _____

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

Asthma _____ Anxiety _____ Attention Deficit _____
 Concussion _____ Depression _____ Diabetes _____
 Fainting _____ Heart Condition _____ Hearing Deficit _____
 Hospitalization _____ 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

MEDICATION ADMINISTRATION: 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 DENY permission for the medications listed above, please check here.** _____

All other medications require a written prescription from your physician and your signed permission.

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, to treat allergic rashes, insect bites, toothaches, minor wound infections and minor burns unless otherwise indicated by parent/guardian.

Parent/Guardian Signature _____ Date _____