Nashoba Valley Technical High School **Grade_____**
School Year 2014-2015 **ID#_____**
Student Emergency and Health Form
(please complete and return to the school nurse)

Student Name _____ Date of Birth _____ Birthplace _____
Last First
Address _____ Town _____ Zip _____ Circle sex: Male/Female

Father/Guardian _____ Address _____ Town _____ Zip _____

Employer _____ Address _____ Town _____ Zip _____

Mother/Guardian _____ Address _____ Town _____ Zip _____

Employer _____ Address _____ Town _____ Zip _____

Parent/Guardian Email: _____ _____

Siblings

Name					
Age					
School					

Telephone Numbers: Include extensions and other prompts.

	Home	Work	Cell	Other
Mother/Guardian				
Father/Guardian				

With whom does the child reside? _____ List address & phone if different _____
Primary language at home: _____

Emergency Contacts: Local persons to be notified in case of 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 Tel.	Work	Cell

Health History: Life Threatening Allergies

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 to the school nurse at the beginning of the school year. All medication requires a written physician's order.

Bee Stings _____ Peanuts _____ Nuts _____ Food (please specify) _____ Other _____ Medications _____

Describe your child's 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 your child carry his/her own Epi Pen? Yes No Asthma inhaler Yes No

Indicate treatment for allergic reaction at school. _____

Please complete reverse side of form.

Illness/Chronic Conditions:

Please list any illnesses your child is being treated for:_____

_____

Does your child have any dietary or physical limitations:_____

_____

(Please note that a note from your child's physician is required to excuse a child from any school activity, including physical education.)

Please add any information regarding your child's physical or emotional status which may help us make their education more productive:_____

_____

Medications: Please list prescription and over the counter medications your child takes. Include herbal treatments.

Name of Medication & Dose	Reason	Home	School

Note: Prescription and over-the-counter medications which your child must take at school require an MD/NP order – please refer to the Medication Policy for details.

Vision Eyeglasses _____ Contact Lenses _____ Date of last eye exam _____

Dental Dental Insurance Yes No Do benefits include? Fluoride ____ Cleanings _____ Sealants ___
Does your child visit the dentist every six months? Yes No Date of last exam _____

Health Care Provider Information:

Physician: _____
Name Street Address Town Zip Telephone

Dentist: _____
Name Street Address Town Zip Telephone

Health Insurance Name of company _____ Mass Health _____ No Insurance _____

Subscriber _____ Policy Number _____ Hospital Preference_____

Confidential Information I grant permission to the school nurse to share health information about my child, on a need to know basis, with his/her teachers and coaches. Yes _____ No _____

Medical Release I understand that the Nashoba Technical High School has a responsibility to my son/daughter to use responsible and prudent judgment in maintaining his/her health while engaged in the school's programs. With this in mind and in my absence: In the event of an injury or illness, I hereby give my permission for my son/daughter to receive medication and/or any other appropriate treatment (including emergency surgery) by an area doctor, hospital or other appropriate medical facility.

Parent/Guardian Signature: _____ **Date**: _____

Health Care Provider Release I grant the school nurse permission to exchange information with my child's health care provider. I understand that I can limit or revoke this consent at any time. Yes_____ No_____

Parent/Guardian Signature: _____ **Date**: _____

Medication Permission

The school physician allows the school nurse to administer acetaminophen (Tylenol) or ibuprofen (Motrin/Advil) as directed for such complaints as headache, cramps or dental concerns. Tums are also available for stomach upset & heartburn. Medications may be given only once per day up to five times in a two week period. Medications required more frequently must be ordered by an MD/NP. Please indicate if you give permission for the school nurse to administer medications to your child: acetaminophen yes/no ibuprofen yes/no Tums yes/no

Parent/Guardian Signature: _____ **Date**: _____