

80 Locust Street
Northampton, Massachusetts 01060

Emergency/Health Form 2020/2021

Dear Parent/Guardian and Student:

Please complete this Emergency/Health Form (both sides) and return it to the School Nurse. In case of a serious medical emergency, the school will make every attempt to contact the parent/guardian or other designate individual. If deemed necessary, your child will be transported by ambulance to an emergency care facility.

Student name: _____ **Date of Birth:** _____

Grade: _____ Shop: _____

Address: _____

Street	Town	Zip code
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Home Phone: _____ Cell Phone: _____

Parent/Guardian: _____

Address: _____

E-mail: _____

Home Phone: _____ Cell Phone: _____

Place of Employment:

Work Phone: _____

Parent/Guardian: _____

Address: _____

E-mail: _____

Home Phone: _____ Cell Phone: _____

Place of Employment: _____

Work Phone: _____

Other Emergency Contacts (If a parent/guardian cannot be reached, the individual listed below can be contacted to assume responsibility and possible transportation of the student):

1st Choice Name: _____ Relationship: _____

Phone: _____ Cell Phone: _____ Work Phone: _____

2nd Choice Name: Relationship:

Phone: _____ Cell Phone: _____ Work Phone: _____

Please turn over to complete the reverse side...

Does your child have Health Insurance: ☐ yes ☐ no

(If you do not have health insurance, the Commonwealth of Massachusetts has an affordable health insurance plan to provide coverage for uninsured families. Please contact the School Nurse for information.)

Health Insurance Provider: _____

Policy Number: _____

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Does your student wear glasses or contacts? ☐ Yes ☐ No

Does your student have a hearing aid? ☐ Yes ☐ No

Health Conditions: _____

Please list any medications, including inhalers, which your child takes daily:

Allergies (please list):

Food: _____

Medication: _____

Other: _____

Does your child have an epi-pen? _____

I give permission for the School Nurse, at her discretion and per school policy and procedure, to give:

☐ Yes ☐ No Acetaminophen 650-1000mg by mouth or an appropriate dose for weight/ age.

☐ Yes ☐ No Ibuprofen 200-600mg by mouth.

☐ Yes ☐ No Tums for gastric upset.

☐ Yes ☐ No **I give permission for the School Nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs while at school.**

☐ Yes ☐ No **I give permission to the School Nurse exchange information with my child's Primary Care Provider for the purpose of referral, diagnosis, treatment, physical exam, and immunization status.**

Date

Signature

Relationship