AMSACS HEALTH OFFICE EMERGENCY INFORMATION 2021-22

Student's Name: ______________________________________ Grade: 6 7 8 9 10 11 12
Last First Full Middle Name (do not use initials)

Address: ______________________ Town/City ______________ Zip Code ________

Home Phone: ________________ Home Email Address: ______________________

Date of Birth: ________ City/State of Birth: ______________ Mothers Maiden Name: ___________

Gender: M F Primary Language: ____________Does your child have health insurance? ☐ No* ☐ Yes

Policy Name: ______________________________ Policy #: ____________________

Student cell phone: _______________________ Student email: ____________________

*If you have no health insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable/free health care (restrictions may apply). Please contact the school nurse for more information about these programs. All communications will be confidential.

Name & grade of siblings in school building: ______________________________

In case of medical emergency, the school will make attempts to contact parent/guardian before calling student's primary care provider (physician). Your child will be transported by ambulance to an emergency care facility if deemed necessary. Please complete physician information

Student's Physician: ______________________________ Phone: ______________
Date of last appointment: __________ List Immunizations given in last year: ______________

Student's Dentist: _____ ____________________________ Phone: ______________
Date of last appointment __________ Does your child have dental insurance? ☐ Yes ☐ No

FAMILY DAYTIME CONTACT INFORMATION

Mother:

Name: ______________________

Address: ______________________

Home Phone: ______________________

Cell Phone: ______________________

Place of Employment: ______________________

Work Phone: ______________ext.: ______

Email Address: ______________________

Father:

Name: ______________________

Address: ______________________

Home Phone: ______________________

Cell Phone: ______________________

Place of Employment: ______________________

Work Phone: ______________ext.: ______

Email Address: ______________________

Other Custodial/Step Parent/Guardian:

Name: ______________________

Address: ______________________

Home Phone: ______________________

Cell Phone: ______________________

Place of Employment: ______________________

Work Phone: ______________ext.: ______

Email Address: ______________________

Please indicate if your child may be released to non-custodial parent in case of illness and/or an emergency
☐ **yes** ☐**no**

Other Contacts

Please indicate names of friends/relative/neighbor that will assume responsibility and provide transportation for your child in case of illness/injury/emergency/school evacuation when parent(s)/guardians cannot be reached. **Your child cannot be released to anyone other than those you list here.**

1. Name: ______________________
Relationship: ______________________
Daytime Phone: ______________________

2. Name: ______________________
Relationship: ______________________
Daytime Phone: ______________________

TURN OVER AND COMPLETE OTHER SIDE PLEASE

Student's Name: ____ Grade: 6 7 8 9 10 11 12

☐ Bus ☐ Parent Pick-Up ☐ Extended Day Program ☐ After School Program
☐ Other (Specify) _______________________________

Please check all that apply ☐ Anxiety ☐ Asthma ☐ Celiac Disease

☐ Heart Condition ☐ Diabetes ☐ Autism ☐ Seizure Disorder

☐ Migraines ☐ Depression ☐ ADD/ADHD ☐ OCD ☐ Lactose Intolerant

☐ Other (Specify) ____

☐ Allergies/Intolerance: To what? (food, insects, medication, environment) Specify __________________

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Does your child have an Epinephrine Auto-injector? ☐ No ☐ Yes Specify _________________

Does your child have a Metered Dose Inhaler? ☐ No ☐ Yes Specify ________________________

Please specify any medications or treatments your child will/may need during school hours: ____________

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Please List all Medications your child is taking at home: ____

Note: Students are **not allowed by law** to carry any medications, over-the-counter or prescriptions. If your child has a medical condition or is on medications, please fill out the required medication forms and contact the school nurse if you have not already done so.

Please Specify Problems with:

☐ Vision ☐ Right ☐ Left ☐ Eyeglasses ☐ Contacts ☐ Preferential Seating

☐ Hearing ☐ Right ☐ Left ☐ Hearing Aid ☐ Tubes ☐ Preferential Seating

☐ Dental ☐ Braces ☐ Other ____

☐ Speech ____

☐ Bone or Joint _________________________________ ☐ Muscular/Skeletal ____________________

☐ Gastro/Intestinal ______________________________ ☐ Kidney/Urinary __ ____________________

☐ Other ____

Does your child have any physical limitations? ☐ No ☐ Yes ___________________________________

Does your child need any special equipment? (walker, wheelchair, etc.) ☐ No ☐ Yes ________________

Has Your Child been hospitalized during the past year? ☐ No ☐ Yes _____________________________

Please send in updated physical exams and immunizations directly to the school nurse as they occur. State law requires health records to be complete to attend school. This form needs to be filled out each year.

- I give the school nurse permission to share this information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. ☐ Yes ☐ No
- I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis and treatment. ☐ Yes ☐ No
- In case of an accident or serious injury and I cannot be reached at the numbers above, I hereby authorize the school to arrange transportation to the nearest hospital emergency room to be treated by the physician on duty. ☐ Yes ☐ No

Signature (custodial parent/guardian) ______________________________________ Date: ____________