WESTPORT COMMUNITY SCHOOLS

Office of School Health Services

Student Medical Update / Parental Consent Form

(Please complete and return to school immediately. Contact school nurse with any questions)

Student Name_____ M / F
Last First Middle

Grade _____ Homeroom/Teacher_____ Date of Birth _____/____/_____

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.

Does your child have health insurance? YES NO Health insurance name _____
Can your child participate in our Physical Education (GYM) program? YES NO

Physician: _____ Phone_____ Last Physical _____
Dentist: _____ Phone _____ Last Exam _____

Student Medical History (**please answer all questions and provide details for each YES response**)

ADD / ADHD	YES	NO	Vision Problem	YES	NO
Autism Spectrum Disorder	YES	NO	Wears Glasses	YES	NO
Asthma / Respiratory	YES	NO	Hearing Problems	YES	NO
Diabetes	YES	NO	Wears Hearing Aide	YES	NO
Emotional Condition	YES	NO	Skin Condition	YES	NO
Gastrointestinal Issue	YES	NO	Allergy to Food	YES	NO
Headaches	YES	NO	Allergy to Medication	YES	NO
Heart Condition	YES	NO	Seasonal Allergy	YES	NO
Seizure Activity	YES	NO	Other Allergy	YES	NO
Bone/joint disease or injury	YES	NO	Does your child have an allergy that requires		
Head injury or Concussion	YES	NO	epinephrine for accidental exposure?	YES	NO

Details of YES responses / Other significant information: _____
_____
_____
(Use back of form if you need more space for details)

Does your child take medication at home? Yes No
If yes, please list:_____
Does your child take medication at school? Yes NO
If yes, please list:_____
(**All** medications given at school must have a physician's order, parental consent and be transported to school by an ADULT)

In case of medical emergency, the school will attempt to contact the parent/guardian before calling an ambulance or the student's physician. Your child will be transported by ambulance to an emergency care facility if necessary. 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. I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis and treatment.

_____ _____
Parent/Guardian Signature Date

Revised 6/2019