Brockton Public Schools
Confidential Student Emergency Information Form

Date_____

Student's Name_____ Grade_____ Room_____
Last First Middle Birth Date_____
Address_____ Brockton, MA 0230___ Place of Birth_____
Home Tel. ( ) _____
Cell Phone ( )_____

Emergencies such as a sudden illness or accident often occur at school. In the event of an emergency, your child will be transported to the nearest local hospital.

Please complete the following information:

Parent 1/Guardian 1 Name	Address	City/Town	Zip	Relation to student
Parent 2/Guardian 2 Name	Address	City/Town	Zip	Relation to student

Child lives with Both ( ) Parent1 ( ) Parent 2 ( ) Guardian ( )
Parent 1/Guardian's Occupation _____ Place of Employment_____
Address_____ City/Town _____ Tel. ( ) _____
Parent 2 /Guardian's Occupation _____ Place of Employment_____
Address_____ City/Town _____ Tel. ( ) _____

Please arrange for **two other** responsible adults to care for your child in the event that you cannot be reached.

Name_____ Address_____
City/Town _____ Tel. ( ) _____

Name_____ Address_____
City/Town _____ Tel. ( ) _____

Please indicate if there are any family restrictions (e.g., current restraining order)

_____

Please indicate if your child has had Chicken pox ___ German measles ___ Tuberculosis ___
Please indicate if your child wears Hearing aid(s) ___ Glasses ___ Dentures or partial plates ___
List any **medications**, or **chronic health conditions** such as eye or ear problems, heart disease, diabetes, asthma, allergies*, seizure disorder, etc. Explanation _____

_____

***Indicate all allergies** (be specific) _____

Physician's Name_____ Address_____ Tel. ( ) _____
Dentist's Name_____ Address_____ Tel. ( ) _____

Health Insurance_____ Policy Number _____
Group Number_____

Has your child had a physical exam within last two years__ yes __no Date_____Last dental visit Date_____

I give permission for the School Nurse to share medical information with the appropriate school personnel and to contact my child's physician as necessary.

Signature of Parent/Guardian_____ Date_____

List other children living in the home.

Name	Date of Birth	Name of School

If you have no health insurance, the Commonwealth of Massachusetts has a health insurance plan that will provide uninsured children with affordable health care (restrictions may apply). If you are interested in more information about this program, please contact the School Nurse.

The school nurse has a doctors standing orders from our school physician to administer Tylenol for pain, fever, Epipen for unknown anaphylaxis, Benadryl by mouth for itching, Hydrocortisone cream for inflammatory rashes, Antibiotic ointment for minor abrasions, and Albuterol nebulization for known asthmatics. I give permission to the school nurse to administer the medications listed above as ordered by the school physician.
Parent/ Guardian signature_____Date_____

Copies: Main Office (original) School Nurse (yellow) and Homeroom Teacher (pink) Effective date 6/30/2015