Hamilton-Wenham Regional School

EMERGENCY MEDICAL CARD

Student _____

Student _____ Gender _____

Homeroom _____ Grade _____

I hereby authorize the Hamilton-Wenham Regional School District, through its medical staff and/or local hospital, its physicians and staff, to act in the best interest of my son/daughter in the event of injury or need for immediate medical attention.

Student: _____ DOB: _____ Adress: _____

Contact 1: _____ Primary _____ Alt _____ Cell _____

Contact 2: _____ Primary _____ Alt _____ Cell _____

Contact 3: _____ Primary _____ Alt _____ Cell _____

Contact 4: _____ Primary _____ Alt _____ Cell _____

Physician: _____ Address: _____ Office Phone: _____

Medical insurance Company Name: _____ Policy # _____

Does your child have any allergies (medication, food, environmental) that we should know of?

Medication		**Does your child have an Epi-pen?**	
Med 1:		Dose/FR	1
Med 2:		Dose/FR	2
Med 3:		Dose/FR	3
Med 4:		Dose/FR	4
Med 5:		Dose/FR	5
Med 6:		Dose/FR	6

Health Conditions:

I consent for the school nurse to exchange information with my child's health care provider in order to meet their health care needs? _____

At the discretion of the school nurse, my child may receive the following over-the-counter medications that have been approved by our school physician. We use Bacitracin Ointment, Calamine Lotion, Antacids, Benadryl, cough drops, hydrocortisone cream, Ibuprofen, Acetaminophen as standing orders for treatment. Please enter any exceptions to these medication below.

TB RISK ASSESSMENT

Was the child born in Africa, Asia & Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or Middle East? _____

In what country was the child born?

Has the child lived or traveled in Africa, Asia & Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or the Middle East for more than one month?

In the last 2 years, has the child lived with or spent time with someone who has been sick with TB?

Have any members of the child's household come to the United States from another country? _____

Which country?

Does the child have any history of immunosupprevise disease or take medications that might cause immunosuppression?

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