Brockton Public Schools
Confidential Student Emergency Information Form
(All Information Must be Completed-No Blanks)

Student Name: **Birth Date**: **Grade**:

Home Room/Teacher **Student ID/Lunch #:** **(BHS) House:**

Home Address/City:

1. Parent/Guardian: **Relation to Student**

Home Phone: Cell Phone: Work Phone: Email:

2. Parent/Guardian: **Relation to Student**

Home Phone: Cell Phone Work Phone: Email:

3. Additional Emergency Contact (local if able)

1. Contact: **Home Phone:** **Cell Phone:** **Work Phone:**

2. **Contact:** **Home Phone:** **Cell Phone:** **Work Phone:**

****Please indicate if there are any parental restrictions (current restraining order):**

Massachusetts State Regulations 102 CMR 7.07, 105 CMR 220 and CMR 200 require all students in Pre-K-12 be fully immunized and have a physical exam upon entry to school and every 3 years thereafter. Please give your School Nurse required information.
Medical or Mental Health Conditions/Allergies: (If no medical/mental health conditions put N/A)
Conditions:
Allergies:
Assistive Devices/Equipment:
Medications (Given at home; and ones to be given at school)

Primary Care Provider: (Do No Leave Blank if no Primary Care Provider put N/A)
Provider Name: **Provider Phone Number:**
Provider Address:

Health Insurance: (Do Not Leave Blank if no insurance put N/A)

Insurance Provider: **Insurance Policy Number**

Please notify the school nurse if you need assistance obtaining a Primary Care Provider or Health Insurance

RELEASE AGREEMENTS: Please visit: bpsma.org/departments/health-services; to review the following documents in full: Nurse Share Information, Doctor Standing orders; Prescription Medications/Treatments, Mass Health Agreement (Summary on Back page)

NURSE SHARE INFORMATION

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

(OVER PLEASE READ)

STANDING ORDERS:

I give permission for the School Nurse to administer the following medications prescribed by the Brockton Public School's Physician:

1. Tylenol for pain and or fever ____Yes ____No
2. Cortisone cream or ointment for rashes ____Yes ____No
3. Benadryl for itching/allergy signs and symptoms ____Yes ____No
4. Triple Antibiotic Cream for minor cuts and abrasions ____Yes ____No
5. Sunscreen minimum of 15 SPF (provided by the parent) ____Yes ____No
6. EpiPen for unknown anaphylaxis ____Yes ____No
7. Anbesol Oral for mouth/tooth pain ____Yes ____No
8. Albuterol Sulfate for asthma ____Yes ____No
9. Tums for stomach aches and or heartburn ____Yes ____No
10. Narcan for drug overdose ____Yes ____No

PRESCRIPTION MEDICATIONS/TREATMENTS

I give permission for the School Nurse to administer any physician/medical provider prescribed medication or treatment for which an official order has been received.

PARENTAL CONSENT TO ACCESS MASSHEALTH (MEDICAID) BENEFITS (This is a Summary)

The school district is asking your permission/consent to share information about your child/children with MassHealth **(Mass Health Agreement**) The information we will share is MassHealth ID, name, date of birth, gender, type of services provided, when the service was provided, and by whom.

School Districts in Massachusetts have been approved to receive partial reimbursement from MassHealth for the costs of health-related services provided by the school district to your child/children.

With your permission, the school district will be able to seek partial reimbursement for services provided by MassHealth.

The school district cannot share with MassHealth information about your child without your permission.

1. The school district cannot require you to sign up for MassHealth for your child to receive the health related and/or special education services to which your child is entitled.
2. The school district cannot require you to pay anything towards the cost of your child's health -related and/or special education services. The school district cannot require you to pay a co-pay or deductible so that it can charge MassHealth for services provided.
3. If you give the school district permission to share information and request reimbursement from MassHealth:
    a. This will not affect your child's available lifetime coverage or other MassHealth benefits outside of school.
    b. Your permission will not affect your child's special education services or IEP rights.
    c. Your permission will not lead to any changes in your child's MassHealth rights.
    d. Your permission will not lead to any risk of losing eligibility for other Medicaid or MassHealth funded programs.

You have the right to change your mind and withdraw your permission at any time (PLEASE SEE FULL DOCUMENT ON BPS WEBSITE): www.bpsma.org/departments/health-services: Release Agreements

___ I have read and reviewed the following release agreements and give permission for the following: (Must answer Yes or No)

Nurse Share Information: ____Yes ____No
Standing Orders: (See Above) ____ Yes ____No
Prescription Medication/Treatment: ____Yes ____No
Mass Health Agreement: ____Yes ____No

Parent/Guardian Signature_____Date: