

Cardinal Spellman High School

Medical Information Sheet

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Student:

Name of Child: _____ Date of Birth: _____ Grade: _____

Name of Parent/Guardian 1: _____

Home: _____ Cell: _____ Work: _____

Name of Parent/Guardian 2: _____

Home: _____ Cell: _____ Work: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Physicians:

Child's Pediatrician/Physician: _____

Phone: _____ Date of Last Physical: _____

Child's Dentist: _____

Phone: _____ Date of Last Cleaning: _____

Immunizations and Medications:

Massachusetts law requires that all children enrolling in school should be immunized- please provide a copy of your child's most recent physical and vaccine record.

- Is your child capable of participation in a full program of school activities, such as physical education?
 - ☐ Yes
 - ☐ No. Please Explain _____
- Is your child taking any prescribed medication(s) on a daily basis?
 - ☐ Yes. Please List Medication(s) _____
 - ☐ No
- Will your child be taking any medications in school?**
 - ☐ Yes**Please List Medication(s) _____
 - ☐ No

**If YES, please complete the Authorization for Prescription Medication Administration form and return with both Parent/Guardian and Licensed Prescriber signatures

If I cannot be reached in the case of an emergency, I hereby grant permission to the school authorities to secure and administer treatment for the above named person. This completed form may be photocopies for use on trips away from school. I give permission to 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.

Signature of Parent/Guardian _____ Date: _____

Student Name:_____ **D.O.B** _____

I give permission to the school nurse to give my son/daughter:

- ☐ Oral Tylenol/Acetaminophen or Ibuprofen for fever or discomfort
- ☐ Oral Benadryl/diphenhydramine for non-life threatening allergic reactions
- ☐ Oral TUMS/calcium carbonate for indigestion
- ☐ Topical bacitracin for mild skin irritation
- ☐ Topical hydrocortisone cream for moderate skin irritation

All above medications are dosed for appropriate age and weight and dispensed only after the assessment of the nurse.

Parent/Guardian Signature_____ **Date:**_____.

Health Concern	Circle one	If yes, please explain:
Does your child have any allergies (including to medicines, food, and/or any other substance)	Yes/No	
Does your child have asthma?	Yes/No	Does he/she need an inhaler?
Does your child have diabetes?	Yes/No	
Does your child have seizures?	Yes/No	
Does your child have ADD/ADHD?	Yes/No	
Does your child have migraines?	Yes/No	
Does your child have a hearing problem or wear glasses/contacts?	Yes/No	Left, right or both ears?
Does your child have depression, anxiety, or any other mental health concern? (please specify)	Yes/No	
Does your child have a chronic illness?	Yes/No	
Has your child ever had a concussion?	Yes/No	Number of total concussions: Date of last concussion: Other relevant information:
Has your child ever had surgery?	Yes/No	
Has your child ever been hospitalized?	Yes/No	
Has your child ever had cancer?	Yes/No	
Has your child ever had a 504, IEP or other educational accommodations?	Yes/No	
Girls only: Does your child experience painful, irregular menstruation and/or is on medication	Yes/No	
Other health concerns?	Yes/No	