

Middleborough Public Schools - Student Health and Emergency Information

School: _____ **School year:** _____

Student's Grade: _____ **Student's Teacher:** _____

Please fill out the entire form (both sides), sign, and return to the school nurse (PLEASE PRINT)

Students name: _____ D.O.B. _____

Address _____

Custodial Parent/Guardian #1: _____

Primary Phone: _____ Secondary Phone: _____

Custodial Parent/Guardian #2: _____

Primary Phone: _____ Secondary Phone: _____

In the event of illness or accident and the parent or guardian cannot be reached, the following individuals are authorized to pick up and assume temporary care of my child:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Please read and initial each applicable item and sign below:

_____ I give the School Nurse permission to share confidential health information with school staff directly working with my child/appropriate school personnel, as well as with my child's physician, on an as-needed basis in order to meet the health and safety needs of my child.

_____ I give permission for my child's physician, listed below, to share pertinent health information with the school nurse on an as needed basis in order to meet the health and safety needs of my child.

Primary Care Physician name and Phone number: _____

_____ I give the School Nurse permission to evaluate my student's illness or injury during school hours, and provide care as needed within the restrictions imposed by the standing orders authorized by the school physician under the state laws of Massachusetts.

Parent/Guardian Signature: _____

Parent/Guardian Name (please print): _____

Date Completed: _____

Please also complete the items on the back of this page.

Health/Medical information

Most recent physical exam: _____ Height: _____ Weight: _____

Does your child have any allergies to food, insects, environment, etc? Please list below.

Does your child have an Epi-pen for any allergies listed above? YES NO N/A

Does your child have any health concerns or conditions of which we should be aware (ie asthma, diabetes, seizure disorder, etc)? Please list: _____

Does your child take medication for any of the listed health conditions? Please include dosage and frequency. _____

The following medications may be given in the MPS nurse's offices under direction of the district physician. Please initial any/all medications your child may receive. By selecting and signing below you give permission for the school nurse to administer the medication(s) listed under standing order from the district physician. All medications are dosed by weight where applicable. Generic form may be substituted for brand name. Parents/guardians may provide over-the-counter to the nurse for their student's use.

Medication	Parent/Guardian initials
Acetaminophen (Tylenol)	
Ibuprofen (Motrin/Advil)	
Cough Drops	
Bacitracin Ointment	
Calamine Lotion	
Hydrocortisone 1% cream or ointment	
Benadryl for allergic reaction	
Epinephrine (Epi-pen) for life threatening allergic reaction (emergency only)	
Clear Eyes/Saline	

Do you wish to be called before medication is administered (except in emergency situations)? _____

Parent/Guardian authorized signature: _____