



# GATEWAY REGIONAL SCHOOL DISTRICT

Blandford Chester Huntington Middlefield Montgomery Russell  
12 Littleville Road, Huntington, MA 01050

School Year 2025-2026

## Student Health Information Form

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Preferred Pronouns: \_\_\_\_\_

Parents/Guardians Names: \_\_\_\_\_

Child lives with: \_\_\_\_\_

Language(s) spoken at home: \_\_\_\_\_

Address: \_\_\_\_\_ Town/Zip: \_\_\_\_\_

Student's Cell#: \_\_\_\_\_ (Optional) Parents will be notified prior to calling a student's cellphone. Text not utilized.

## Emergency Contacts

**Please list parent/ guardian and 2 other responsible adults who may pick up your child**

1st Name:	Relationship	Phone #
2nd Name:	Relationship	Phone #
3rd Name:	Relationship	Phone #

## Medical Information

Student health conditions: \_\_\_\_\_

Please list any allergies: \_\_\_\_\_

Please list any medications currently being taken at home: \_\_\_\_\_

Does he/she need medication at school?  YES or  NO Name of Medication: \_\_\_\_\_

Does your child have a Special Individualized Health Care Plan:  YES or  NO

Is your child enrolled at the School Based Health Center:  YES or  NO

**Please indicate if your child has the following diagnosis:**

**Life Threatening Allergy**  YES or  NO / EpiPen prescribed:  YES or  NO

**Life Threatening Allergy to:** \_\_\_\_\_

**Asthma**  YES or  NO / Uses Rescue inhaler  YES or  NO

**Seizures**  YES or  NO

**Diabetes**  YES or  NO      **Depression/Anxiety**  YES or  NO      **ADHD/ADD**  YES or  NO

**Cardiac Conditions**  YES or  NO/ Specify: \_\_\_\_\_

**Hearing Difficulties** (Please Specify) \_\_\_\_\_ **Vision Problems** (Please Specify) \_\_\_\_\_

**Other :** \_\_\_\_\_

Please send the **Medication Order** and **Emergency Action Plan** (if applicable) to the nurse before school starts. New orders are required each school year. Nurse private fax phone# HS/MS: 413-667-3048, Chester: 833- 284-9093 Littleville: 833-259-4133 Children with inhalers or EpiPens, if deemed appropriate by the prescribing provider can self-administer, please have the provider indicate that on the medication order. Example: "Can carry and self-administer". For all other medications, they must be brought in by a parent/guardian in their manufacturer labeled container, no more than a 30 school day supply. In addition to the above, a consent form for administration must be signed in accordance with state regulation



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105CMR210.00. Medications can be retrieved on the last day of school by end of school day. Medications not collected will be destroyed.

**Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I give my permission to the school nurse to administer the following over-the-counter medications to my child, according to established protocols, as indicated by my signature below.

Acetaminophen (Tylenol)	YES	NO
Ibuprofen	YES	NO
Calagel (Anti-itch gel)	YES	NO
Burn Spray	YES	NO
Eye Wash Solution	YES	NO
Wound Wash	YES	NO
Petroleum Jelly (Vaseline)	YES	NO
Hand Sanitizer	YES	NO
Sunscreen SPF 45 or greater	YES	NO
Hand lotion no fragrance	YES	NO
Albuterol (Emergency)	YES	NO
Narcan (Emergency)	YES	NO
Epinephrine aka EpiPen (Emergency)	YES	NO
Diphenhydramine (Benadryl)	YES	NO
Cough Drops (Grades 6-12)	YES	NO
		N/A

- I understand I may call the school nurse for more information.
- To the best of my knowledge, my child has no allergy/sensitivity to any of the above named products.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**All other medications require a written MD order, parental permission & Medication Administration Plan**

In case of an emergency, the school will attempt to contact a parent/guardian before calling a student's primary care provider. If necessary, your child will be transported by ambulance to an emergency care facility.

- I give permission for the school nurse to share relevant health information with my child's health care provider for referral, diagnosis or treatment for this school year. \_\_\_\_\_(Initial here)
- I give permission to my child's doctor \_\_\_\_\_ to release to the school nurse information which they believe to be in the best interest of my child. \_\_\_\_\_(Initial here)
- I give my permission to the school nurse to share information relevant to my child's health with appropriate school personnel. \_\_\_\_\_(Initial here)
- I give my permission for the school nurse to share this form with emergency responders in the event of an emergency as well as to treat and transport my child to a hospital if I am unable to be reached. \_\_\_\_\_(Initial here)
- My signature below attests that the information on this form is correct. Should any changes occur, I understand that I am responsible for notifying the school nurse. I have read, understood, and completed this form to the best of my ability. I understand that I may contact either school nurse at any time with questions, concerns, or updates.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Insurance Provider: \_\_\_\_\_ Insurance group/certificate #: \_\_\_\_\_



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Additional Community Providers: \_\_\_\_\_ Phone: \_\_\_\_\_

**(Please Circle one) Private Health Insurance / Public Health Insurance/ No Insurance**