Dudley-Charlton Regional School District
68 Dudley-Oxford Road
Dudley, MA 01571

Phone: (508) 943-6888
Fax: (508) 943-1077
www.dcrsd.org

STUDENT HEALTH INFORMATION SHEET

*MUST BE COMPLETED AND **SIGNED ANNUALLY***

Student name:____Date of Birth:__________________

School name:___________________________________Grade: _________________ ▢ Male ▢ Female

Family Doctor/Practice:_______________________________________Phone number: __________________

Primary contact in the event of an emergency during school hours:

Contact #1:__________________________Phone:______________________ Relationship:_______________

Contact #2:__________________________Phone:______________________ Relationship:_______________

Contact #3:__________________________Phone:______________________ Relationship:_______________

In the event of an emergency, the school may make whatever arrangements seem medically necessary. ▢ **yes** ▢ **no**

Student Health Information Please fill out completely

All health information is considered confidential. It may be shared with staff as needed during the time your child is enrolled in the Dudley-Charlton Regional School District in order to ensure the health and safety of your child.

Health/Medical History:____

Allergies:____

Hearing/vision (tubes, hearing aids, glasses, contacts,etc.):____

Daily Medications (list name, dose & frequency):____

Potential life threatening conditions:

Severe allergy requiring emergency medication: ____

Reaction: ____

Seizure disorder: ▢ yes ▢ no Emergency medication: ▢ yes ▢ no Date of last seizure: ______________

Severe asthma (regularly takes medication): ▢ yes ▢ no Emergency medication: ▢ yes ▢ no

Diabetes: ▢ yes ▢ no Emergency medication: ▢ yes ▢ no

Other:____

Medication consent:

▢ I give permission for the school nurse to administer over the counter medications included in the DCRSD district orders.

(Tylenol, Motrin, Benadryl, Zyrtec, Tums, Calamine lotion, Hydrocortisone, Neosporin, Bactine, Bacitracin, Sterile eye irrigation, Burn gel, Anbesol/ Orajel, Vaseline, cough drops, Callergy lotion, Lactaid, Sting wipes, Antiseptic wipes, Biofreeze)

To **decline** specific medications for your child, **please list**:

____

____

Signature of Parent/Guardian:____**Date:** __________________